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ADOLESCENT OPIATE ADDICTION: A CASE STUDY*

BY DONALD L. GERARD, M. D., AND CONAN KORNETSKY, Ph.D.

Introduction

In an earlier report,[1] some of the general social and psychiatric characteristics of 32 minor male opiate addicts were described. It was noted that though they were youthful—minors—they were genuinely addicted to opiates. Although they came from a variety of ethnic backgrounds, the vast majority were Negro and Puerto Rican youths residing in run-down, low-status neighborhoods of New York City or Chicago. Their families, variable in structure and patterns of relationship, were of the types which psychiatric experience suggests are productive of serious difficulties in adjustment. The adolescent addicts observed fitted into the following diagnostic categories: (a) overt schizophrenia (b) incipient schizophrenia or "borderline" states (c) delinquency-dominated character disorders (d) "inadequate" personalities.** Independent of their psychiatric diagnoses, each displayed a patterned disturbance or syndrome of characteristics consisting of (a) dysphoria, (b) problems of sexual identification, and (c) disturbed interpersonal relationships with their peers and with adults. These characteristics, neither subtle nor well controlled, were extreme and often obvious handicaps to effective functioning in any setting.

These diagnostic types and the general psychopathologic characteristics are familiar to workers in psychiatric settings. In themselves, however, they convey little of the feeling of what adolescent opiate addicts are like, and no explicit insights into the motivations or processes involved. The present paper, which is a detailed case study, is intended to illustrate; first, the kinds of data from which the previously reported findings were abstracted; and second, to give one example of the highly-individualized process of becoming a drug addict.

Case History

Jay R. was 20 years old when he was admitted to the United States Public Health Service Hospital in Lexington, Ky. He was a highly intelligent, well-built and handsome Negro youth of Brit-

*This case was studied while both authors were commissioned officers in the United States Public Health Service, assigned to the Juvenile Addiction Project, Laboratory for Socio-Environmental Studies, National Institute of Mental Health.

**These diagnostic terms were defined and discussed in the earlier report cited (Ref.1).

ish West Indies parentage. At the time of his admission he had regularly been using heroin intravenously for two years. The heavy tattooing of his antecubital forearm veins, together with moderately severe withdrawal symptoms, indicated that he was genuinely addicted to opiate drugs.

I. *Family Background*

Jay R. was born in New York City. He lived with his parents in his maternal grandmother's apartment until he was about four years old. The relationship between his parents was strained. Much of the friction centered around the problem of establishing a separate residence; and at Jay's father's insistence, a separate one was briefly established. However, tension and discord between the parents did not abate; after a short time in their own home, Jay's father deserted and moved to California. Jay and his mother then moved back with the grandmother and remained there until Jay was nine.

Although Jay's mother disliked and feared her mother, who was insulting and provocative, she was never able, except sporadically, to break this relationship. Jay's grandmother was described by both Jay (to us) and his mother (to a psychiatric social worker of a community agency) as quarrelsome, interfering, manipulative, and hypocritical.

Jay's mother worked as a stenographer in a hospital, and Jay was cared for by the grandmother. From the age of nine to 11, Jay and his mother occupied an apartment together without the grandmother; from 11 to 12 they again lived with her. From the time he was 12, he and his mother lived together in a three-room apartment without the grandmother, but close enough to her for the grandmother to remain an almost daily figure in Jay's life. He had no further contact with his father from the time of the desertion until Jay was 18.

The relationship between Jay's mother and grandmother was a major motif in Jay's development. They quarreled frequently and bitterly, disparaged each other in Jay's presence, and openly struggled to gain control over him in an attempt to keep him from each other. His grandmother was financially secure. She promised him anything he wanted: e. g., to support him through private school and college, *if he would leave his mother* and live with her. She would emphasize these bribes by not assisting Jay's occasion-

ally destitute mother, although she would state to welfare agencies that she was giving Jay and his mother, full support. Despite the grandmother's financial security, Jay was not infrequently hungry. His grandmother beat him for misbehavior and aggressively attempted to control his social living, attempting to force her puritanic, rigid, and moralistic ideals upon him. This was especially confusing, as the grandmother periodically drank excessively.

Jay's mother suffered from bronchial asthma throughout her life. Both before and during his adolescence, Jay cared for her during acute asthmatic attacks as well as in her periods of invalidism. During his adolescence she was an "understanding" listener to recitals of his problems and feelings. In Jay's own terms, they were closer than boys usually are with their mothers. She expected Jay to care for her as if she were weak and helpless, but she brutally punished him whenever she learned he had been involved in fights with boys. On one occasion, she spanked him publicly in front of his schoolmates when his teacher reported in a note to her that Jay had fought in school.

In addition to being brought up with middle class goals and values, Jay was exposed to cultural interests which were atypical in his community. His mother played classical music on an old upright piano, read intellectual plays and poetry, and preferred listening to the "highbrow" New York City radio stations (WNYC, WQXR). In the British West Indies, both the father's and mother's families were well-educated landowners, lawyers, or teachers of classical music.

II. *Personal Adjustment*

Jay has a long history of difficulties in living. He was shy and withdrawn, had "only one friend," who had little contact with him. When they were together they spoke little, restricting their companionship to doing things like building model airplanes or playing with photography. Occasionally, they would go fishing. Jay was enuretic, with occasional daytime incontinence, until he was 15 years old. In order to protect himself from the street gangs who picked on him, "because I was different," he carried a pistol. Though the patient acquired a reputation as a gunman and tough guy, wounding other boys on at least three occasions, he carried the gun in conscious desperation and fear. At 16 he was picked up by the police after he had wounded a boy in a gang street fight.

The court planned to send him to a correctional institution but instead allowed his persuasive grandmother to take him to Trinidad. In Trinidad, he was unable to take advantage of educational and occupational opportunities offered by his successful uncles and cousins. He was unhappy there because he feared that his uncle would learn about his "gangsterism" and poor school achievement.

Upon his return to New York at the age of 17, he obtained a job in a photographer's studio and for a while showed definite improvement in his relationships with people. Jay began to make strong efforts to associate with his peers; he forced himself to talk with them, to become friendly, and engage in group activities; but, although he participated, he felt on the outside. He feared, despite his efforts, that the other boys would respond negatively to anything he might say. He anticipated that they would not like him and that they would think he was crazy. He anxiously wondered why he felt that every man around him wanted to fight with him, and why he was so sure that all the other fellows felt that they could beat him up.* Despite his shyness, he was more comfortable with groups of girls than with groups of boys. Jay quit his job when several less experienced white boys were promoted ahead of him to more skilled and better paying positions. He then worked briefly as a stock clerk in a large department store during the Christmas rush. Following this temporary employment he enlisted in the army.

After basic training, Jay was sent to Guam as a military policeman. On one occasion he shot at a soldier who teased him. For the last six months of his active military service he was becoming an alcoholic, drinking two to three pints of saki every day to "get relaxed." Despite this, he was not involved in any disciplinary actions in the army. According to Jay—and with some verification—after he had been in the army for a year, his mother had an exacerbation of her asthma and applied, through the Red Cross, for assistance. They arranged for her to receive dependent's pay. Jay was then discharged from the army "without honor" on the basis of falsely stating in his enlistment application that he had no dependents. Afterward his case was reviewed, and an honorable discharge was issued.

*An incident which occurred while Jay was hospitalized typified his earlier attempts to be liked. One of the other patients provocatively accosted him and said, "I don't like you." Jay smiled in a friendly manner, although he thought, "I wanted to break his head," and replied, "Well you're alright with me."

When Jay again began to live in New York City with his mother, he was despondent and discouraged. He found himself again involved in the familiar quarrel between his mother and grandmother. In the course of a quarrel in which his grandmother screamed and cursed at his mother, Jay became upset, went to the bathroom and drank a bottle of tincture of iodine. He fainted, was taken to a general hospital, and then to the psychiatric division of Bellevue. He avoided psychiatric observation by asserting that he had mistaken the iodine bottle for cough medicine. It was in the setting of his discouragement over the failure of his army career, and his untenable family situation, that Jay first came in contact with narcotic use in his community.

III. *Opiate Drug Use*

A. *Initial contact with heroin use.*

Shortly after returning to New York from the army, Jay made three visits, about a week apart, to a grammar school acquaintance. Each time he found the same group of three or four boys sitting around, "dreamy looking." They offered him heroin. He had heard negative things about "dope fiends," and refused each time. As he walked out following his third refusal, they began to tease him and to call him a "square." Jay recalled, "I didn't like being called a "square" . . . I wanted these fellows to like me . . . so I decided to try some."

B. *The developing pattern of drug addiction.*

After Jay changed his mind, he let these boys give him a skin "shot"; a few minutes later he vomited. He then returned to his mother's apartment, took a shower, and then sat comfortably in a chair. He then began to feel drowsy, half awake and half asleep; he was "on the nod." He found this rather puzzling (frightening) but soon began to feel pleasantly relaxed. The next evening "he found himself" receiving a shot again, and every night thereafter for a week. Each time he was given the shot. After a week, he was induced to accept an intravenous injection ("main line") in order to get a better effect from less of the drug. Not until he had passively received heroin intravenously three times, was he able to inject the drug into his veins himself. Jay continued using drugs every day, taking his shot at night.

In the early stages of his drug use, Jay observed addicts who were completely "down," ragged, poor, and homeless. He learned rapidly from others that heroin was habit-forming. He promised himself that he would never let drug use lead him to such a state.

Several weeks after Jay began using heroin, he felt restless and tense while at work. A fellow worker told him he would feel all right if he took a shot during the day. Jay then began taking heroin twice daily. He soon recognized that to continue getting "high,"* he would have to increase his dosage; otherwise he could only "keep normal," that is, prevent withdrawal symptoms. Indeed, had Jay been content to take drugs only to prevent withdrawal symptoms, his habit would have remained economically manageable.

After he had been using heroin for five months, he was "taking off" four or five times daily and gradually increasing the quantity of drug used in each injection. A year after Jay had begun to use opiates, his habit cost approximately $16 a day. Jay exhausted his savings, pawned his clothing and camera equipment, and then quit his job in a photography laboratory because it did not pay enough to support his habit. He began shoplifting and housebreaking, alone and with another addict. In Jay's terms, "The drugs got me."

This type of passive interpretation for a deepening involvement with opiates ("The drugs got me") is one of the more common and —to the therapeutic investigator—most frustrating façades used by drug addicts. Later, when Jay entered into a therapeutic relationship, he dropped this passive façade and became capable of formulating and communicating the many important changes he experienced through using opiates. As the writers explored these changes, his family background and personal adjustment before drug use became also more meaningfully detailed. These new data are purposefully integrated with his statements about drug use, rather than placed in the foregoing sections of this paper, to emphasize that they became available gradually in the process of therapy.

*The term "high" as used by drug addicts refers to the desirable psychic effects of heroin or other opiates. The main characteristics of the "high" as the writers were able to reconstruct them from patients' reports consist of a feeling of detachment and relaxation, which is graphically expressed among addicts by the expression "being in junkies' paradise." Being "high" means being "out of this world," separated from the tensions and complexities of one's present living.

C. *Functional significance of opiate drug use.*

Some of these changes can be formulated in simple before-and-after terms. This is not to say that Jay perceived them or interpreted them this way. Indeed, he usually became aware of them against his resistance; despite abundant evidence, he preferred to ignore or deny the functional relationships of any of these changes to his addiction. However, Jay demarcated four areas in which his difficulties in living were altered through opiate drug use. These were: (1) fantasy living; (2) obsessive symptomatology; (3) socialization; and (4) the relationship with his mother.

1. Fantasy living. One of the popular fallacies about opiate drugs is that they release a flood of imaginative, elaborative, or creative thinking. The writers' clinical experience suggests, to the contrary, that the fantasy living that young addicts have while under the influence of opiates is impoverished, infantile, and stereotyped. Jay was no exception to this generality. However, there were striking changes in his fantasy living that were produced by his opiate use.

Before his addiction, Jay often had elaborate daydreams. Though his fantasied roles and situations varied, the thematic structure of these daydreams was constant. Some of the role situations of his fantasies were: being a pilot of a large passenger plane, a surgeon performing a delicate operation, a military leader. Regularly, at the beginning of the fantasy, Jay anticipated a successful and happy outcome, like Walter Mitty. Everything went well. However, as his fantasy developed, Jay became preoccupied with feelings of incipient failure. The tenor of the fantasy shifted. Instead of competently executing his role, he made a blunder at the crucial moment. The fantasy then blurred out, and Jay was left with lowered mood and a feeling of pervasive anxiousness. In his fantasies, Jay is in a position of prestige and authority. The lives of helpless individuals are in his hands. He fails them and disasters ensue. In the course of Jay's addiction his fantasies were not altered so that they had successful or happy endings. The significant change which occurred to these recurrent daydreams was that *they ceased.*

A similar blotting out of disquieting thoughts occurred in another area of his living. Prior to his addiction, while reading or studying at home, Jay frequently became anxiously aware that

something was troubling him. He recognized that it had something to do with the relationship between himself and his mother. Despite almost obsessive efforts to find out more explicitly what specific thing in the relationship was bothering him, this remained vague. Unable to return his attention to his reading or studying, he would hurl his book across the room, rush outside, and walk the streets until his tension abated.

During his addiction, Jay was often alone at home. He might read or otherwise occupy himself, yet this sequence of preoccupation, tension, restless movement, did not occur. The significant effect which opiate addiction had upon Jay's fantasy living consisted in blotting out his dysphoric fantasy living and his anxious preoccupation about the relationship between himself and his mother.

2. Symptomatology. The term "drive" is often used by addicts to describe an increased ability for motor and sometimes ideational activity while under the influence of opiates. It is difficult for addicts to communicate what "drive" means to them and why the "drive" is perceived as a valuable experience. Part of this difficulty is related to defensiveness and evasion. However, the more basic determinant of their inability to communicate subtle and personalized aspects of the "drive" they experience with opiates is that this requires exploration beneath their façade of denial. In the writers' experience, "drive," and other subtle aspects of opiate effects, usually become understandable after they have been related to the addict's concealed psychiatric symptoms, or to aspects of his living of which he is ashamed. Although Jay used the term "drive" freely in early interviews, it was not until he was able to discuss his obsessive symptomatology, that the writers understood what "drive" meant to him.

About six weeks after Jay entered the Public Health Service Hospital, he was assigned, at his request, to work in the furniture shop. He sought this placement because of his prior interest in handicrafts and model-making. However, he became perturbed because he could produce (in his estimation) only about one-third as well as other patients doing the same tasks. He noted that he worked excessively slowly and carefully, as he feared that the supervisor would be sure to inspect the one piece of his work which might not be perfect. As the writers explored these obsessive difficulties in motor expression, Jay recalled that before his use of

heroin, he was similarly handicapped. The following difficulties in motor expression, which occurred before his use of drugs, were reported.

(a) He would begin work on a model airplane, almost reach completion, and then quit. When he went back to his work table, he would leave the partly completed model and start a new one.

(b) He had contracted to make belts and pocketbooks for women in his community. Despite the fact that he would be well paid for his work, he would often sit at home from morning to night looking at a piece of work he had started without being able to continue with it.

(c) Concerned with the neatness of his clothing, Jay wanted to shine his shoes before going to work or school. He was able to shine them only after what he described as "a great effort of will."

These difficulties in motor expression were accompanied by obsessive ruminative thoughts about whether it was worth while for him to begin or complete a project, about the adequacy or inadequacy of his workmanship, and about the hopelessness of his existence.

In the course of his addiction, Jay recalled that striking changes occurred in his capacity for motor activity. When he arose, he took his shot of heroin, shined his shoes, carried out his handicraft projects, and so on, without hesitation or inhibiting thoughts. It was this whole area of change in motor expression which Jay referred to in addict terms when he said using heroin gave him "drive."

3. Socialization. As long as Jay could remember, he had worried about whether his attempts at relating with boys or girls were acceptable. At parties, he placed himself at the edge of a group, unable to participate in conversation or activity. He felt chronically threatened and under judgment. He feared others would not like him or accept him, feared that they thought him crazy. He recognized that these thoughts were irrational and at times tried to argue himself into feeling differently. Sometimes he forced himself, but with little success, to feel confident, to trust and talk with people.

In the course of his addiction, Jay found these feelings were markedly altered. He didn't care whether people found what he had to say acceptable, nor was he preoccupied with thoughts of his unacceptability or inadequacy. He became comfortably aggressive

and outgoing in his social living. On the other hand, he felt less need or motivation to associate with people; after a while he didn't care about anything besides getting more heroin. The problems which he experienced in socialization were increasingly less in his awareness, as he shifted his energies from attempts to live better with people toward living better with himself, that is, with more heroin. Before his addiction Jay tried to maintain a passive and agreeable façade in order to be friendly with everyone. While using drugs, he became irritable, touchy, and aggressive.

4. Relationship with his mother. (a) Jay had had the same girlfriend for seven years at the time he entered Lexington. On several occasions they had planned to marry. However, each time it was Jay who suggested a postponement, at first because he felt he was too young and later, after he had returned from the army, because he was using drugs. Jay felt that he had become attracted to his girlfriend because of the many physical and temperamental similarities between her and his mother.

(b) While at Lexington, Jay expressed a strong desire to get away from his family because he could not bear to be involved in the arguments and tension over him between his mother and grandmother. He said he would like to go to California and live with his father, whom he had met briefly in California, when Jay was going overseas. However, when the social service department at the hospital in Lexington offered assistance in tracing his father, Jay reneged because he "didn't want my father to know" that he was a drug addict. Despite what Jay expressed as his better judgment, he planned to return to New York to live with his mother.

These data, together with the content of his preoccupations, emphasize the strength and importance of the ambivalent ties between Jay and his mother. In attempting to clarify his decision, Jay was able to bring up the following new material which suggests that the pattern of living associated with illicit drug use also was integrated with his relationship with his mother.

When Jay returned to his mother after his army experience, he found that his mother had a paramour who helped support her and lived with her. When the paramour discovered that Jay was using drugs, he stopped contributing to Jay's mother's support. When Jay stole one of the paramour's suits and pawned it, the paramour broke up with Jay's mother and moved away. When Jay went to Lexington, the paramour moved back again.

Jay avoided discussion of the significance of this relationship for him. Indeed, the writers were able to learn little from him about it and his feelings about it except that it disturbed him and he could not cope realistically with it.

Jay did not tell his mother when or whether he was returning from Lexington to New York. The last letter he wrote his mother, about three weeks before he was discharged, stated that he was going to join his father in California. Consequently, when he arrived, she and her paramour, who were again living together, were surprised and angry over his unexpected return.

At the writers' suggestion, and with the co-operation of the social service department at Lexington, the Community Service Society of New York City offered their services to Jay. They sought out for him educational opportunities, ego-acceptable employment, and living quarters away from his family. However, Jay refused to accept these opportunities. Instead he found a night job doing kitchen work, and planned that his grandmother, with whom he lived, would support him through a high school equivalency program at a private school in New York.

Jay could not give a coherent story of what happened then. However, within a month after Jay's return from Lexington, his mother's paramour left her apartment, and Jay moved back with her. Interestingly, while he had been living with his grandmother, Jay worked and stayed out of trouble despite her vituperative and moralistic criticism. When he returned to live with his mother, who again was unable to work because of her "asthmatic" condition, Jay became bored, upset, and unhappy. He then returned to using drugs.

When the writers saw Jay about two months after he left the hospital, he was readdicted to opiates, unemployed, and stealing to support his habit. In the interview with him at this time, he was bland, cool, and relaxed. He lied gracefully. He was able to avoid awareness of the consequences of his delinquency and failed to recognize interpersonal implications which a month before he was able to formulate rather well.

Discussion

Jay's history shows that long before he began to use heroin, he was a severely maladjusted boy with episodic delinquent behavior occurring in a context of a basically schizoid, obsessive-compulsive

personality orientation.* Jay's prolonged and close contact with two seductive and controlling mother-figures, the desertion by his father at the time of his early Oedipal conflicts, and the discrepancy between the cultural values of his family and those of his peers are among the evident experiential sources of his personality difficulties. In his relationships with his peers, he expressed a tremendous need for acceptance, even tolerating insult in the hope of being accepted. He was uncomfortable with boys, all of whom, he felt, wanted to, and could, beat him up. With girls he was shy, yet at ease. These data suggest both confusion in sexual identification and an anxious concern over homosexual trends. In Jay's initial experience with drugs, he was able to avoid heroin use and felt no compelling need to gain acceptance from a group of heroin-using boys until they called him a "square." This term, which colloquially means "not being a real man," plausibly mobilized some anxious awareness of his underlying sexual confusion. By accepting heroin in the setting of this group interaction, Jay was able to help repress his conflicting feelings about his sexual identification and role. Accepting heroin became a concrete proof of "being a real man."

The changes which Jay experienced in his living, through the use of opiates, were, in a broad sense, therapeutic. It was preferable for Jay to live without his distressing fantasy life, ruminative preoccupations, and obsessive motor symptomatology. Developmentally, becoming irritable and aggressive in social relations following drug use may be considered a positive movement away from his need to please and placate everyone. Dynamically, Jay needed to maintain his regressive and incestuously tinged relationship with his mother.

*Jay was diagnosed by the writers as borderline schizophrenic (Ref. 2) on the basis of his life history, types of difficulties in relationship and on the basis of projective psychological testing. The writers used the term, "borderline schizophrenic," to describe patients who were struggling against an active disorganizing and disruptive process in which they experienced extreme anxiety, related to feelings of inadequacy and lowered self-esteem. Paranoid trends and early thinking disturbances were noted. Though moralistic, and though striving and struggling toward conventional goals in work, marriage, and education, these patients found themselves unable to carry out their required roles and relationships. Their hold on reality was tenuous. In situations which caused stress to them, they became unrealistic and confused. They strove to maintain intellectual controls and to avoid situations which required emotional participation.

The ambivalent ties between Jay and his mother appeared to the writers to be a major dynamic factor in the continuation of his drug use. Unable to leave her maturely or to remain with his mother without guilt, Jay was able, through his drug use, to rationalize postponement of a more mature, responsible relationship with his girlfriend, to drive away his mother's lover, and to maintain his dependent and mutually-destructive relationship with his mother. Achieving these dynamically valued goals was facilitated and rationalized by the pattern of living associated with drug use. Unlike the direct acting out of negative or hostile impulses (which Jay's obsessive needs prohibited), the interpersonal consequences of his drug use could be perceived by Jay as accidental and unpremeditated. The basic logic was simple: "I do not do this, drugs lead me to these actions, I regret their occurrence, but I am not really responsible or guilty." Whatever feelings of wrong-doing or tension might be left over after this "logical" treatment could be cared for through the bland detachment (the "high") achieved from the drug itself.*

Although Jay's case is unique in the particulars of his experiences, relationships, and symptomatology, it typifies in several important aspects, the cases the writers have studied.

Conclusions

1. Opiate addiction among adolescents extends out of a long history of serious difficulties in living.

2. It is often feasible after a few months of a therapeutic investigative relationship:

   (a) To clarify the types of functional changes in living which positively motivate the adolescent to deepen his involvement with opiate drugs;

   (b) To formulate cogent and/or plausible hypotheses about the integration of opiate drug use within a particular adolescent addict's personality structure and interpersonal experience.

*Consideration of the physiological mechanisms through which opiates affect behavior is beyond the scope of this paper. A review of the pertinent literature is available in a monograph by Wikler (Ref. 3). Current experimental literature (Refs. 4 and 5) suggests the stimulating hypothesis that morphine (and, presumably, the other opiates) reduces the disruptive influence of anxiety produced by anticipation of pain. Clinically, this suggests that one of the functions of the opiate for addicts is to alleviate the anticipatory distress and anxiety associated with guilt—in the psychoanalyic rather than the popular sense—related to unconscious wishes or strivings.

3. A major difficulty in the treatment of opiate addiction among adolescents, that is, in assisting these youths to live without opiates through lessened needs for heroin and for the associated pattern of living as a drug addict in our culture, is the fact that opiate addiction is so valuable and efficacious for them in their attempts to cope with their difficulties and symptomatology. Despite this, the authors do not believe that psychiatric treatment, including psychotherapy and structured environmental situations, for these youths is fruitless. The writers plan to discuss some of their experiences and hypotheses concerning the treatment of adolescent opiate addicts in a later report.

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THE USE OF METHEDRINE IN PSYCHIATRIC PRACTICE

BY JAMES A. BRUSSEL, M. D., DAVID C. WILSON, JR., M. D., AND LEWIS W. SHANKEL, M. D.

For a dozen years psychiatrists have been intensifying an unremitting search for diagnostic adjuvants for the making of rapid and irrefutable classifications. Associated with this pursuit, is the hope that such agents might also have therapeutic powers or at least indicate the treatment pattern to be followed. The writers' attention was therefore turned toward methedrine (methamphetamine hydrochloride), and with the co-operation of its manufacturers,* it was possible to study this pharmaceutical and its action in psychiatric use.

Methamphetamine is the U. S. P. (XIV) term for d-desoxyephedrine and d-N-methylamphetamine and these are marketed under such trade names as "methedrine," "privitin," and "desoxyn." The drug is a member of the group of sympathomimetic amines which includes ephedrine and amphetamine. In addition to its general sympatheticotonic properties, it exerts a stimulant action on the cerebral cortex, varying from mild euphoria to excitement. Because of this central stimulation, (increased alertness, euphoria, and decreased sense of fatigue) methedrine has been recommended whenever elevation of mood is required.

Rudolph[1] treated several depressed patients, ranging in age from 24 to 89 years, and reported considerable success. He administered methedrine orally. Levine[2] and his co-workers studied the psychological and physiological effects of methedrine when given intravenously. They found that the optimum dosage was 20 mg. in 1 cc. of water, a plan that the writers followed in their patients. Levine selected cases with schizophrenic and cyclothymic psychoses and reported that methamphetamine produced an emotionally-charged, free flow of material which included painful memories, traumatic experiences, intimate personal fantasies and delusional ideas. Most of their patients experienced dramatic relief of tension and a feeling of relaxation. In contrast to sodium amytal, methamphetamine caused no loss of consciousness or amnesia for the interview so that all that had been said was available to the patient's consciousness for further and later integration and interpretation.

*Burroughs Wellcome & Co., Inc.

Delay[3] studied and compared methedrine and the short-acting barbiturates; he considered methedrine to be a "psycholeptic," producing a lowering of intrapsychic tensions and depressing psychological tone. Delay found that manic features and depressive phenomena were exaggerated in cyclothymic psychoses, and, therefore, regarded methedrine as a useful adjuvant in diagnosing atypical cases. In depressions, amytal enabled the patient to externalize depressive patterns of ideas by decreasing anxiety, while methedrine forced their production by increasing anxiety. In schizophrenia, amytal lessened catatonic features while methedrine intensified them. Combined amytal-methedrine investigation was regarded as desirable in neuroses for encouraging abreaction.

For the purpose of the present investigation a group of patients was selected to include: (1) depressive, introspective psychosis, (2) uncommunicative, resistive paranoid schizophrenia, (3) stammering as an example of outward, somatic expression of a deeply, internally-imbedded conflict, (4) the claim by a psychopath that his difficulties were due to amnesia, and (5) the possibility of bilateral action by methedrine in producing and/or relieving functional manifestations of organic symptoms.

Results will be reported by discussing representative cases, but it can be said that many reactions and results, noted elsewhere in the literature, were not duplicated by the writers; while other unanticipated events occurred. The most alarming of the latter was a rapidly occurring and transient neurological complication in a young woman that was first noticed within 36 hours after methedrine, 20 mg., had been administered intravenously, and that disappeared within another 24 hours. At the time of admission, her physical examination was essentially negative, aside from a mild peripheral neuritis attributed to avitaminosis which rapidly yielded to proper dietary additions. The central nervous system involvement was ushered in by a generalized convulsion initiated by a typical cry, and followed by cyanosis and vomiting. A nurse who witnessed the attack averred that the convulsion had commenced with an aura of visual hallucinations and delusions. Some photophobia continued for the rest of that day. The patient suffered the convulsion even though she had received sodium luminal, gr. 2, intramuscularly four hours before for sedative purposes. She continued to be cyanotic and had intermittent muscular tremors throughout the day. Oxygen and intravenous phenobarbital

sodium were of considerable help. Electro-encephalographic records immediately after the attack (Figure 1) revealed paroxysimal bursts of 6-8 per second activity with moderate amplitude most prominent in motor leads. EEG examination 48 hours later produced a normal record (Figure 2).

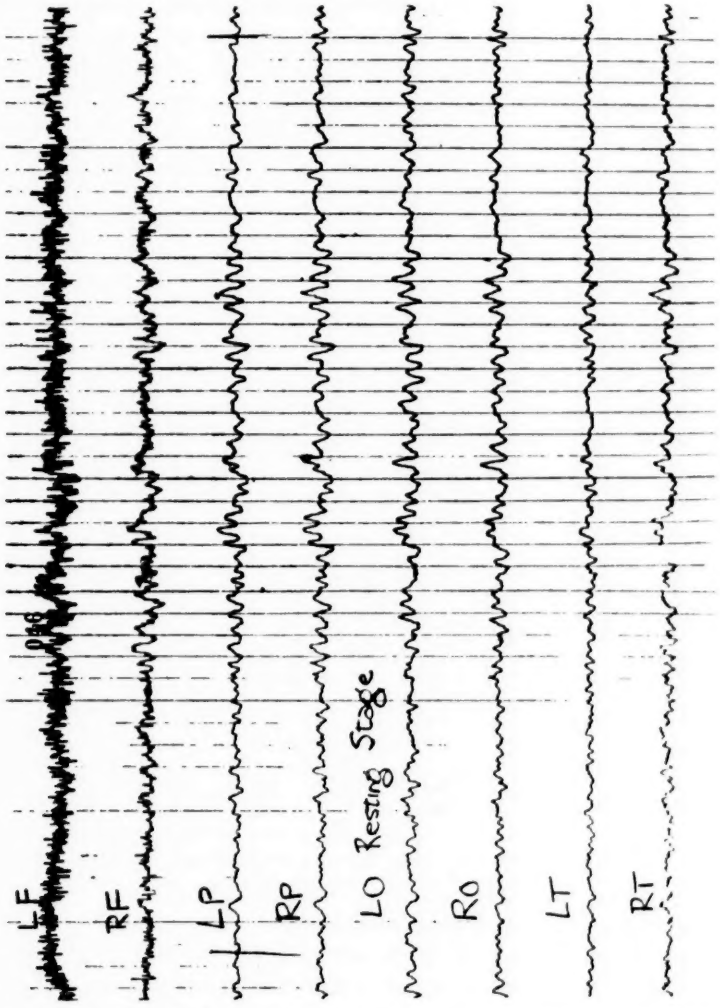

Figure 1. Electro-encephalogram taken 72 hours following administration of methedrine (36 hours after onset of convulsions), showing paroxysmal 6-7/sec high voltage activity.

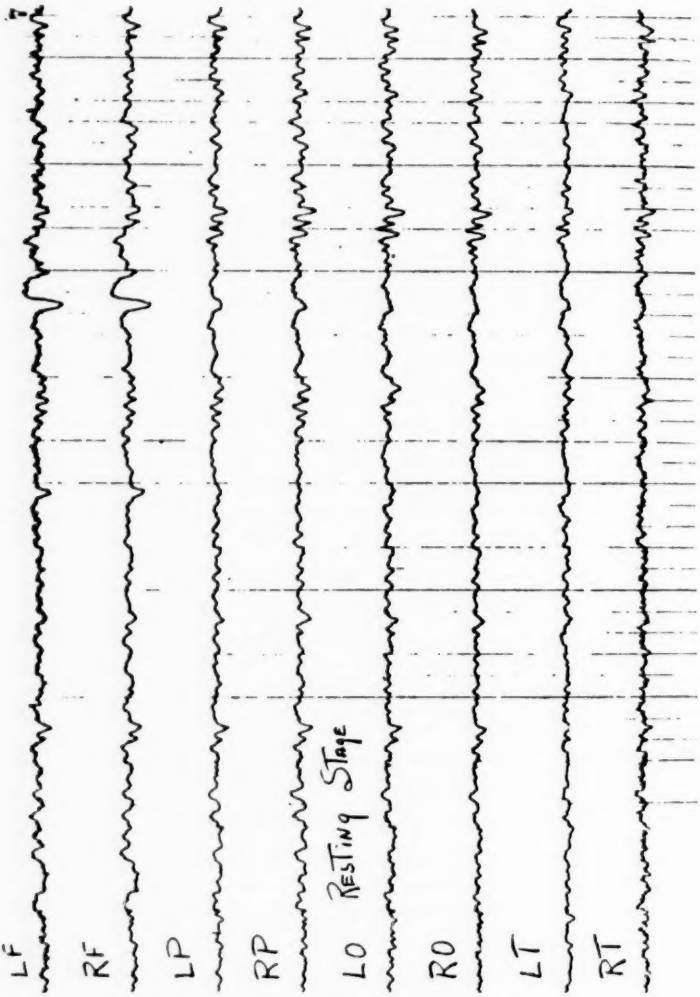

Figure 2. Electro-encephalogram taken five days after administration of methedrine, showing no paroxysmal activity and a basic 10/sec alpha rhythm.

The stammering and stuttering patient showed marked somnolence following a methedrine interview. He fell into a deep sleep from which he awoke in a few hours and attempted to go to the bathroom. Here he became extremely dizzy and unsteady, and he fainted, suffering a laceration of the forehead. He was returned

to bed, having regained consciousness promptly, but he showed no neurological residuals, and he did not suffer syncope again. During his methedrine interview, the stammer had failed to disappear but the stuttering element did. The following day, the elevation of mood, the hyperproductivity of words and spontaneity of expression, all noted during the interview, were in evidence. No change in these findings was noted two days later; he continued to be relatively elated, but now showed extraverted tendencies in that he took note of those about him on the ward and began to take an interest in the behavior of other patients.

Psychotic patients in this investigation became very tearful during the height of the methedrine interview without this depressive feature having been noted as part of the total syndrome: i. e., the paranoid, suspicious and resistive schizophrenic patient had not been expected to resort to tears. In this instance, it was the writers' opinion that she became depressed and wept because she was unable to check the flow of words that methedrine was forcing her to release. In keeping with Delay's findings,[3] the depressive patient who wept during the methedrine interview had not resorted to tears before this session, even though he was deeply depressed.

It is recommended that blood pressure readings be made several times before methedrine investigation, since patients—particularly anxious neurotics and suspicious psychopaths—may evidence hypertension when they see the syringe and hypodermic needle. No patient of the present group showed any appreciable rise in blood pressure during the actual interview, but pulse rates invariably rose, sometimes as much as 40 per minute. There is a physiological-psychical correlation, in that the height of pulse rate corresponds to the maximum of "speech push," both occurring about 15 to 20 minutes after intravenous administration of methedrine. Another common finding was thirst, occurring principally at this peak of mental-somatic output. Third, both cyclothymic and schizophrenic patients became markedly hyperactive. This hyperactivity varies from an inability to lie in one position for more than a few seconds to an almost uncontrollable thrashing about the bed.

Push of speech is a universal finding in methedrine administration. If only for this feature, the drug is of invaluable assistance in psychiatry, for no patient seems able to resist the compulsion to verbalize. This includes the underproductive depressive and the tight-lipped, resistive, un-co-operative paranoid. Methedrine

achieves its diagnostic zenith, because of this push of speech, in the psychopath who feigns amnesia.

Successful unearthing of material in the neurotic under the influence of such agents as pentothal sodium or amytal depends on the unconscious desire to unburden guilt feelings, painful material, etc. These forms of investigation are invariably unsuccessful with the psychopath. However, when methedrine is used *with* amytal (gr. 7.5 in 20 cc. of water administered very slowly), the increase in production progresses too rapidly for the psychopath's conscious to edit and control; and, sooner or later, he "tips his hand" by making some statement that contradicts one made before the drug intervention. It is a remarkable experience to watch one of these individuals during the procedure as he turns his head from side to side, his eyes darting furtively from person to person, consternation written all over his face as he realizes consciously that he cannot check his flow of speech at least long enough to weigh his words.

Methedrine and amytal exert reciprocal effects, the latter breaking down "speech resistance" and the former preventing amytal narcosis and having a "pushing effect" on the verbal association processes. Within a half hour after administration the psychopath is talking so rapidly he cannot "stop to think"; he pours out what prove to be correct data in contradistinction to the false data he has previously supplied investigating authorities. In other words, during a methedrine-amytal interview, psychopathic lying is useless to the individual shamming amnesia.

In the cases about to be cited it is impossible to give the recorded interviews verbatim because of space limitations. However, where indicated, excerpts will be quoted.

Case Material

Case 1. R. M. W., a 33-year-old white wife of a soldier, was admitted to the United States Army hospital in a state of confusion and psychomotor hyperactivity. She felt that her family never had wanted her and had "ganged" up on her. Her father had died in a flash fire in her presence, seven years ago, although her husband had pulled him out of it. The husband is described as lazy, leaving all work for his wife to complete. There are eight brothers and sisters, all successful, toward all of whom the patient is hostile. She refers to many beatings at home, and a lack of se-

curity there. Her education included one year of college, made possible by a scholarship earned in high school. Her mother had taught her that sex "was bad." Consequently, she always had felt guilty about intercourse and had gone for months at a time without sleeping with her husband.

This patient had had several episodes of depression with suicidal attempts. In 1949 she received electric shock therapy from a private physician on an out-patient basis. According to the husband, this "helped very little." During the same year, she had a "female operation" and was treated for a ruptured disc, refusing surgical intervention for the latter. For some time, she had been drinking heavily; during 1947 and 1948 she consumed as much as a quart of wine a day. While in Germany with her husband she began to take sleeping pills. Although she had recently abstained from alcohol, she continued to consume heavy doses of "tuinol" and "dormison." During the three years before hospitalization, marital difficulty and drug indulgence both increased; and four days before admission she became acutely confused while on the way to a new home in Santa Fe. On the trip her husband tossed a lighted cigaret out of the car window and the trailer caught fire. In this her pet dog died.

The patient now became more disturbed, suffered hallucinations and delusions, and increased her drug dosage. On hospital admission, the physical examination was negative except for a moderate peripheral polyneuritis which was attributed to avitaminosis. This yielded to proper dietary therapy and an initial intravenous administration of glucose. Her postmethedrine neurological complications have already been mentioned. She was ultimately diagnosed as a paranoid type of schizophrenia, but before detailed evaluation of the case could be made and before definitive therapy could be initiated, she was removed from the hospital against advice.

Just before her methedrine interview, the patient was resistive and confused, demonstrating a jerky type of speech, and varying emotionally from smiles to marked suspiciousness and irritability with angry outbursts. Her gait was peculiar in that she seemed to walk unsteadily on a broad base. Considerable persuasion was required to induce her to permit the injection of methedrine, and she wailed about "allergy to penicillin, barbiturates and cocaine." Once she exposed her buttocks and said, "The butt is the place to

inject a needle." During the first few minutes following the drug-injection, she was defiant, refused to answer questions, and made challenging grimaces as she stuck out her tongue. With the fifteenth minute she began to weep, showed facial flushing and marked unrest, and it was obvious that she was desperately trying to fight the words that poured from her lips . . . words that were direct answers to questions now being fired at her in quick succession.

Deep underlying factors of her disorder, hitherto unobtainable, now appeared. These included a frank distrust of the husband, sexually and spiritually, fear of man in general, dating back to severe corporal punishment in childhood at the hands of her father, and an unvarying suspiciousness of all men. For the next few days that she remained at the hospital and following recovery from her neurological complication, she was rather co-operative, amenable to questioning, less paranoid and suspicious, and, in contrast to her unmannerly behavior on admission, very "ladylike." Because of her sudden departure from the hospital it has been impossible to determine how long this change lasted.

Case 2. B. N. S., a 21-year-old white, unmarried, marine, a private first class, complained on hospital admission: "I am all nervous and worried about things at home." He had been admitted while en route to a new station. His history was essentially "negative" and free of psychiatric illnesses. He had recently completed marine "boot camp" basic training during which time he was "very nervous," the butt of ridicule because of his ineptness and (according to him) because he was a Jew, and his life-long habit of stammering became much worse. He believed that "the others" were talking about and plotting against him, and he feared to sleep lest he be harmed. On the plane en route to his new station he became extremely nervous, anxious, agitated, and suffered auditory and visual hallucinations.

Physical examination on admission revealed a mild pharyngitis, and a slight systolic "blow" at the apex, while laboratory examinations were all within normal limits. Rorschach examination produced a total of 11 responses, and he rejected Cards II, VI, VII and IX. There were indications of sex shock and latent homosexual tendencies, with interpersonal relationships underdeveloped. There was no indication of psychosis but rather of a severe neurosis manifesting itself as hysteria with a dissociative reaction.

Clinically there was marked dependency, and immaturity. The patient had a pronounced stammer with an added element of stuttering. Following admission, he was apprehensive and seclusive.

During the methedrine interview, B. N. S. remained faced away from the examiner, looking at the floor, speaking softly, and placing his left hand over his mouth. After the administration of methedrine the patient seemed notably to have less difficulty with his speech; although the stammering defect continued, the stuttering element completely disappeared. He was now able to speak more quickly than at any other time. There seemed to be a more spontaneous flow of thought. He appeared to be in better spirits, with a lessening of depression. An obsessive fear of being returned to duty with the marines was again manifested, but with less affect. The hand-to-mouth gesture was not present, although, when interviewed, the man continued to turn away from the examiner. Following the session, the patient remained for only a few days, since he had to be transferred to a marine hospital. However, at the time of his discharge the various post-interview improvements noted were still in evidence. The final diagnosis was dissociative reaction, acute, severe.

Case 3. F. D. R., a 28-year-old, single, white man, was hospitalized for neuropsychiatric observation. He had had three years of active duty and was to have been discharged to inactive status. Two days before this discharge, he was hospitalized because he had been disoriented and incoherent for the previous 24 hours. At that time speech was rambling, attention poor and memory faulty. There was evidence of paranoid ideation. His father describes the patient as having been seclusive, aloof, easily upset, but reasonably neat, clean and well-behaved, although he never mingled with others. He was said to have cried easily and was often a "sad child," "brilliant but freakish in mind."

The patient had never cared for girls and was chiefly interested in art—painting. The father had been institutionalized in 1921 for a mental condition that is still in evidence. Death of a sister in 1940, due to a "premature senility," was described as a severe blow to the patient, and he was hospitalized two years later at a mental hospital in Texas for an acute catatonic reaction. He received 23 electric shocks and was discharged 18 months later as improved. The family tree includes many patent instances of non-institutionalized schizophrenia. The patient completed high school

with honors, and thereafter had no record of asocial or criminal activity, either in civilian or military life. Upon admission, he was very confused and agitated, with increased psychomotor activity. He was thought to be hallucinated, although he answered no questions and seemed to be out of contact. Physical and laboratory examinations were within normal limits. At times he would meagerly respond, but usually he would stare impassively at the examiner and remain silent.

Within 13 minutes following administration of amytal and methedrine, this man sat up, commented on people and furniture in the examining room, and smiled on one or two occasions, while weeping on others. He co-operated pleasantly and completely in question and answer procedures, revealing a great deal of material that included the feeling he was King of England, in love with his dead sister whom he had regarded as "his sweetheart," and revealing past feelings of depression with suicidal plans. In the latter he named specific places (such as the Empire State Building) and definite dates. He unashamedly revealed homosexual experiences during adolescence, the hearing of God's voice and other unseen voices mouthing homoerotic remarks and condemnations. He stated that he was the Spirit and the Holy Ghost, that he had forsaken the world ("all of his people"), and that he lived "only in spirit."

He was one of the psychotic patients who complained throughout the interview of thirst and had to have water at frequent intervals. During the remainder of his hospitalization, until his transfer to a veterans' institution, he never forgot the material revealed under the influence of the drugs and showed no reluctance to discuss his many hallucinations, delusions and aberrant ideas. Prior to transfer, he had a full course of insulin shock therapy and responded favorably in that he abandoned many of the more bizarre ideas he had entertained on admission and no longer complained of annoying hallucinations. This case clearly indicates the usefulness of methedrine in causing patients to reveal fully pertinent psychiatric material immediately after admission, thereby facilitating diagnosis and selection of a proper therapeutic program at the earliest possible moment.

Case 4. This case can be summarized as that of an individual who had been AWOL for several months and who, when picked up, pleaded "amnesia" for the period of unauthorized absence. Prom-

inent among his complaints were (1) the inability to remember his date of birth and (2) his mother's first name. At the time of admission he answered questions readily, albeit slowly and studiously, weighing his words carefully. Psychological tests revealed a psychopathic personality.

Under methedrine, the interview was started with routine questions. For the first few minutes, the patient smiled smugly as he answered in a slow and measured manner, believing he was being unaffected by the injection. As he began to yield to the speech-push effect of methedrine, as evidenced by a swifter flow of words and facial flushing, he began to show frank fear and concern. He perspired profusely, and turned beseeching eyes to the examiner as if he were begging for something to enable him to stop talking. Several times he rose as if he would run from the room. He began to realize that he could not hesitate, that he was speaking without thinking or caution, and worse, could do nothing about it. In the seventeenth minute after methedrine injection, the tempo of questioning was stepped up to a rapid-fire pace, and the following verbatim excerpt was completed in a matter of seconds:

Q: What kind of work did you do while in Trenton?
A: Cook . . . second cook . . . I . . .
Q: Where was your first job?
A: At the ——— Grill.
Q: How long did you work there?
A: I don't know . . . please . . . maybe two months . . .
Q: Why didn't you stay?
A: I got drunk . . . they fired me . . . please let me . . .
Q: Then where did you work?
A: At the ——— Hotel.
Q: Then where?
A: At a lunch wagon . . . I don't want to . . .
Q: Didn't you have a social security card?
A: Sure, I did. What has that . . .
Q: Where did you get the card?
A: Where does anyone get it? At the post office . . .
Q: Didn't they question you at the post office?
A: Sure, they did.
Q: Didn't they ask you your age?
A: Sure, but . . .

Q: What did you tell them your birthday was?

A: May 6, 1924 . . . Oh, Jesus . . . [The patient began to wring his hands, weep, and babble incoherently that "They'll throw the book at me now."]

Q: Okay, okay. You know the jig is up. Now, what is your mother's maiden name?

A: Martha ——— [The name was given but is omitted here.]

Later, when the drug effects had worn off, he was interviewed and gave his entire history covering the period of AWOL, filling in many "blanks" for which he had previously pleaded "amnesia." His hospitalization was terminated in a matter of days.

Case 5. This patient was a 21-year-old, white, "war bride" from Ireland. She was extremely pretty, possessed a beautiful figure, and is said to have won a national beauty award in Ireland when she was 17. Her complaint on admission was "uncontrollable epilepsy" which dated back to early adolescence. Her background and history could not be substantiated by social service investigation; most of the data were supplied by the patient and her husband. It is said that she saw the murder of her mother by the patient's father when the patient was 12 years old. The father had made an incestuous attack upon his daughter, and she fled the home, never to return.

Then began a life of sexual promiscuity that persisted even after marriage. When she ran away from home, she also "ran away" from religion, and this abandonment of orthodox Roman Catholicism was reflected by strong guilt feelings. She held many odd jobs in London, but usually spent her time in cheap hotels with American soldiers. She finally married an unsuspecting young officer who brought her home with him. Their brief marital career was marked by bickerings, fights and sexual maladjustment, in that she manifested a strong aversion for relations with her husband, although she had many extramarital affairs. In the two months preceding hospitalization, she would suffer a major convulsive episode whenever he berated her for her coldness toward him. Prior to this he had never seen her in a fit, although she had told him when they first met, that she had suffered such "spells" as a child. Psychological testing and clinical evaluation led to a diagnosis of a severe neurosis with marked anxiety and conversion features.

Methedrine was of interest in this case in that, under its influence, she revealed many significant "unconscious" factors, and, dur-

ing the eighteenth minute after injection, she produced a typical text-book picture of a major convulsive seizure *on command.* Classical features included a cry, tonic-clonic succession, lip-biting, and unconsciousness after the attack. The inference was that suggestion is rendered more persuasive when fortified with methedrine.

Case 6. Briefly, this was a young man who had been hospitalized because of complete aphonia initiated under marked circumstances of stress. Physical, laboratory and other examinations quickly ruled out organic causes. These examinations were completed during the first 48 hours of hospitalization. The man "conversed" by means of pencil and paper.

Under methedrine, he was permitted to write responses during the first quarter of an hour after the injection. Then, as he showed flushing and perspiration, he was told that he could now talk and would continue to be able to talk. At once he was able to speak and continued to do so up to the time that he left the hospital several days later.

Summary

1. A preliminary report is offered concerning the use of methedrine (methamphetamine hydrochloride) in psychiatric practice.

2. In addition to further inquiry, more data is needed to determine if the cerebral stimulation linked with methedrine may not reach a point of irritation with ensuing convulsive phenomena. Likewise, in view of the contraindication to its use in the presence of cardiovascular handicap, a question arises as to possible alteration of cerebral circulation, leading to confusion and syncope as seen in one patient. Evidence that its effect is transient is corroborated by electro-encephalographic tracings on one patient.

3. Methedrine seems to control certain psychic speech disorders, notably stammering.

4. Common reactions to methedrine are tearfulness, increased pulse rate, thirst, and, in psychotic patients, restlessness. The maximum increase in the cardiac rate corresponds to the maximum output of speech.

5. Push of speech is a universal finding under the influence of methedrine. It is this feature which places the drug in a unique position as a psychiatric adjuvant. The psychopath, who feigns amnesia or withholds vital information that he covers with lies or

cautiously alters as he shrewdly weighs his words, is powerless under the influence of methedrine. Once the drug takes effect, the tempo of productivity and the insurmountable urge to pour out speech give the liar no time to think. Likewise, the same mechanism is an advantage when approaching uncommunicative, resistive and suspicious psychotic patients. Even functional aphonics can be expected to recover their speech. Finally, unlike amytal, methedrine is not handicapped by alteration in awareness—and the patient, therefore, does not later "forget" the material he has produced. Thus, therapist and patient can use the production of significant and otherwise unconscious factors to hasten diagnostic understanding and treatment that might be hampered if this material were either not available or were forgotten by the patient.

6. It would seem that methedrine enhances suggestibility, particularly in neurotic individuals. Symptoms, such as aphonia can be removed, while others, such as neurotically-founded epilepsy, can be produced on command.

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A NEW AID TO INSULIN COMA THERAPY

BY R. K. GREENBANK, M. D.

When deep insulin coma is given to patients in the treatment of schizophrenia a new system of control appears to be needed. Present technique, as utilized by most hospitals, consists of the intramuscular administration of a dose of insulin calculated by a subjective method to produce coma within a few hours. The patient enters coma at an uncontrolled rate of speed and reaches a depth which varies from day to day. After a relatively short period (an hour or less) the patient is brought out of this coma by the use of glucose.

The deficiency of modern techniques is shown by the multitude of variations of the foregoing that have been tried. These, briefly, include:

Administration. Insulin of various types and concentrations has been given subcutaneously; intramuscularly (alone or with hyaluronidase); and intravenously, quickly or by slow intravenous drip.

Depth. Patients have been allowed to go to variable depths of coma for variable lengths of time.

Termination. Termination has been brought about by glucose solution, orange juice and/or various other artificial solutions orally; by glucose solutions rectally; and by glucose intravenously. Even intrasternal glucose infusions have been utilized. Each of these methods has provided only partially satisfactory control of the coma situation, and fatalities are still too frequent. Certain of the difficulties with the past and present methods have already been mentioned. Additional problems for the insulin therapist have been the following: 1. Convulsions occur when they are not desired. 2. There are difficulties in finding veins for intravenous termination of coma (which often is a necessary procedure in an emergency situation). 3. Greatly disturbed patients often make otherwise simple intravenous techniques difficult. 4. The depth of coma and, therefore ultimately, its duration are usually controlled for the patient by such variables as weather, an unknown candy bar, menstruation, fluid intake, etc. 5. The dose of insulin must be accurately estimated to prevent either of two extremes, (a) no coma on a given day or (b) rapid fall to a depth that may be inadvisable for the patient, and thus unsafe. 6. It is necessary to terminate

coma early in clinically doubtful patients, to prevent prolonged comas, physical collapse, etc.

In an attempt to remedy this situation, subcutaneous clysis has also been used, but it has been discarded because of frequent sloughs, lack of adequate absorption and painful after-effects.

* * *

The discovery of the "spreading factor," hyaluronidase, manufactured by different firms as "Hyazyme," "Aladase," "Wyadase," etc., has opened a new vista on this portal of entry problem. This permits subcutaneous absorption of clysis fluids at rates close to those allowed by intravenous techniques without the previously mentioned undesirable side effects. It occurred to the author that the use of an intermittent subcutaneous clysis of 10 per cent glucose in Ringer's lactate solution with hyaluronidase would give the physician more control over the patient than was hitherto possible.

Technique

The method used has been to start the clysis when stage III (pathological reflexes, pinpoint pupils and no pain response) is reached. Using a disposable Y tubing (commercially available) and No. 22 clysis needles, the infusion is started in both thighs by a nurse; 150 units of hyaluronidase is then injected into each of the tubings just after the clysis is started.

The rate of flow, which can be as high as absorption of 1,000 cc. per hour, is regulated by the doctor using a small clamp supplied in the kit. The rate is altered to keep the patient's clinical level as desired.

The absorption is fast enough to awaken most patients from a deep coma in 20 minutes, and slow enough to keep the patient's level of coma under the physician's control. To the writer's knowledge, this method has not been reported in English literature.

Results

Major advantages of this technique, as shown by statistical studies covering 2,500 deep coma treatments, and as gained from the impressions of physicians on the insulin service, include:

1. The level of coma is definitely regulated without necessarily bringing the patient to termination.

2. Convulsions are prevented without terminating the coma for the day.

3. Veins are spared for definite emergencies so that, if intravenous termination is needed, it can be done at once.

4. From the patient's point of view, there are no painful and disfiguring hematomas in the case of bad veins.

5. Physical activity of the patient does not modify the effectiveness of this method.

6. Fewer days are found in which coma is missed, since higher doses can be safely used.

Disadvantages of the technique are few:

1. The cost is slightly higher than that of intravenous termination.

2. Somewhat more attention is called for by the physician, to regulate the rate of flow of the clysis than is needed for the older method.

* * *

A theoretical possibility of this method is the prolonging, up to at least several hours, of the length of deep insulin coma given in a single day. This would result in savings in hospital time and in expense to the patient.

Summary

A new method of controlling insulin coma has been developed. It lessens some of the difficulties which have complicated deep insulin coma therapy.

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A STATISTICAL STUDY OF PATIENTS IN THE NEW YORK CIVIL STATE HOSPITALS, MARCH 31, 1952

BY BENJAMIN MALZBERG, Ph.D.

There were 96,898 patients on the books of the New York civil state hospitals on March 31, 1952, the largest number recorded up to that date. On June 30, 1942, there had been 83,092 patients on the books. Thus, in a little less than 10 years, the population grew by 13,806, or an average of 1,416 per year. This occurred despite a decrease of 1,195 between June 30, 1942 and March 31, 1944. The progress of this growth is shown in detail in Table 1, which shows the population on the books of the civil state hospitals from 1920 to 1952. In 1920, that population totaled 38,294, or 366.2 per 100,000 of the general population. With few exceptions, there was a steady growth to the maximum shown, 96,898, or 636.8 per 100,000 population on March 31, 1952.

Of this last total, 43,830, or 45.2 per cent, were males, and 53,068, or 54.8 per cent, were females. The corresponding percentages for the general population were 48.8 and 51.2, respectively, indicating a relative excess of females among the patients. This is a consequence of lower death rates among females and greater longevity. There has been a slowly growing excess of females in the state hospitals. They represented 53.6 per cent of the total hospital population on June 30, 1920, compared with 54.8 per cent on March 31, 1952.

The growth of the patient population is associated with important changes in characteristics, such as those with respect to the age distribution, and to the relative frequencies of the several groups of mental disorders, both of which have important consequences. These have a bearing upon changes in rates of discharge, and upon rates of mortality. A growth in the number of the aged among the patients will (other things being equal) increase the death rate and decrease the discharge rate. It is of importance, therefore, to study the characteristics of the patients on the books.

Table 2 shows the age distribution of the patients on the books of the civil state hospitals on March 31, 1952. Very few were under 15 years of age, this group including only 0.4 per cent of the total of 96,898. Classification by age group shows a maximum of 10,125 at ages 50 to 54, or 10.4 per cent of the total, and then a

Table 1. Patients on the Books of the New York Civil State Hospitals

Date	Males	Females	Total Number	Total Rate per 100,000 general population
June 30, 1920	17,752	20,542	38,294	366.2
June 30, 1921	18,543	21,193	39,736	374.9
June 30, 1922	19,271	21,620	40,891	380.6
June 30, 1923	19,394	21,908	41,302	379.4
June 30, 1924	19,845	22,407	42,252	383.0
June 30, 1925	20,444	23,157	43,601	387.6
June 30, 1926	21,002	23,417	44,419	384.7
June 30, 1927	22,096	24,214	46,310	391.1
June 30, 1928	23,134	25,398	48,532	399.9
June 30, 1929	24,007	26,149	50,156	403.5
June 30, 1930	25,045	26,985	52,030	412.6
June 30, 1931	26,061	27,891	53,952	424.8
June 30, 1932	27,706	29,154	56,860	444.6
June 30, 1933	29,334	30,479	59,813	464.4
June 30, 1934	30,970	31,866	62,836	484.6
June 30, 1935	32,076	33,296	65,372	500.7
June 30, 1936	33,493	34,895	68,388	520.3
June 30 1937	35,040	36,241	71,281	538.6
June 30, 1938	35,962	37,557	73,519	551.8
June 30, 1939	37,165	39,158	76,323	569.1
June 30, 1940	38,324	40,490	78,814	583.7
June 30, 1941	39,125	41,826	80,951	603.4
June 30, 1942	39,847	43,245	83,092	632.1
March 31, 1943	39,322	43,250	82,572	638.9
March 31, 1944	38,227	43,670	81,897	647.0
March 31, 1945	37,711	44,383	82,094	654.4
March 31, 1946	37,969	44,765	82,734	621.4
March 31, 1947	38,803	45,720	84,523	606.9
March 31, 1948	40,061	47,406	87,467	611.5
March 31, 1949	41,548	49,241	90,789	619.4
March 31, 1950	42,845	50,764	93,609	631.2
March 31, 1951	43,714	51,822	95,536	636.3
March 31, 1952	43,830	53,068	96,898	636.8

steady decrease to 5,635, or 5.8 per cent, who were aged 80 or over. The average age was 53.9 years. As usual, the females were significantly older than the males, the average ages by sexes being 55.1 and 52.4, respectively.

The average age has risen steadily for several decades (Table 3). The patients resident on June 30, 1915 had an average of 48.0 years. By March 31, 1930, the average age of the resident population had risen to 49.3 years. Seventeen years later (March 31,

Table 2. Patients on the Books of the New York Civil State Hospitals, March 31, 1952, Classified According to Age

Age (years)	Number			Per cent		
	Males	Females	Total	Males	Females	Total
5- 9	53	14	67	0.1	*	0.1
10-14	209	79	288	0.5	0.1	0.3
15-19	532	532	1,064	1.2	1.0	1.1
20-24	1,397	1,135	2,532	3.2	2.1	2.6
25-29	2,155	2,036	4,191	4.9	3.8	4.3
30-34	2,866	3,006	5,872	6.5	5.7	6.1
35-39	3,519	3,914	7,433	8.0	7.4	7.7
40-44	4,226	4,679	8,905	9.6	8.8	9.2
45-49	4,548	5,129	9,677	10.4	9.7	10.0
50-54	4,691	5,434	10,125	10.7	10.2	10.4
55-59	4,173	5,727	9,900	9.5	10.8	10.2
60-64	4,361	5,510	9,871	10.0	10.4	10.2
65-69	3,999	4,830	8,829	9.1	9.1	9.1
70-74	2,954	4,010	6,964	6.7	7.6	7.2
75-79	2,068	3,218	5,286	4.7	6.1	5.4
80 or over	1,953	3,682	5,635	4.5	6.9	5.8
Unascertained	126	133	259	0.3	0.3	0.3
Total	43,830	53,068	96,898	100.0	100.0	100.0

*Less than 0.05.

Table 3. Average Age and Standard Deviations of Patients on the Books of the New York Civil State Hospitals on Specified Dates

Date	Average age (years)			Standard deviation (years)		
	Males	Females	Total	Males	Females	Total
March 31, 1952	52.4±0.05	55.1±0.05	53.9±0.04	16.7±0.04	16.8±0.03	16.8±0.03
March 31, 1951	52.1±0.05	54.8±0.05	53.6±0.04	16.6±0.04	16.6±0.03	16.7±0.03
March 31, 1950	51.8±0.05	54.4±0.04	53.3±0.04	16.6±0.04	16.6±0.04	16.6±0.03
March 31 1947	51.0±0.06	53.5±0.05	52.4±0.04	16.1±0.04	16.0±0.04	16.1±0.03
March 31, 1930*	47.8±0.04	50.7±0.04	49.3±0.03	14.8±0.03	15.0±0.03	15.0±0.02

*Resident patients only.

1947), the average age of the patients on the books was 52.4 years. The difference between 1915 and 1947 is enhanced by the fact that the resident population is about a half-year older than the patients on the books. After 1947, the average age continued to rise. The averages were 53.3 years on March 31, 1950, 53.6 on March 31, 1951, and 53.9 on March 31, 1952. The same trend is evident if

one compares median ages. Thus, the median age of the resident population was 47.3 years in 1915, and 48.8 in 1930. The median ages of the patients on the books were 52.4 in 1947, 53.4 in 1950, 53.7 in 1951 and 54.1 in 1952.

The rise in the average age is due to a steady and significant increase of those aged 60 or over. The number in this age group among the resident population in 1930 was 11,705, or 24.9 per cent of the total. On March 31, 1947, there were 84,523 on the books, of whom 28,065, or 33.2 per cent, were aged 60 or over. Three years later, March 31, 1950, the total patients had grown to 93,609, of whom 33,719, or 36.1 per cent, were aged 60 or over. There was a further growth on March 31, 1952, when those aged 60 or over included 36,585, or 37.8 per cent of the total.

As a result of this steady shift in the age distribution of the population in the state hospitals, important consequences have arisen, some of which are indicated by the data summarized in Table 4. On June 30, 1920 there were 38,294 patients on the books of these hospitals, of whom 22,708, or 59.3 per cent, were diagnosed as dementia præcox. This group grew to 55,984 on March 31, 1952, but relative to all patients there was a reduction to 57.8 per cent. On the other hand, those with psychoses with cerebral arteriosclerosis grew from 614 to 8,326, or from 1.6 per cent of the total to 8.6 per cent. The senile psychoses grew from 1,276 to 5,266, or from 3.3 to 5.4 per cent.

Together these two groups represented 4.9 per cent of the total in 1920, but 14.0 per cent in 1950. This shift is due in large part to the great increase in the admissions of elderly patients, resulting from the aging of the general population. It is also of interest to observe that, despite the noteworthy decrease in the number of first admissions with general paresis, the number of such patients on the books increased from 1,365, or 3.6 per cent of the total, on June 30, 1929, to 3,559, or 3.7 per cent, on March 31, 1950. This has resulted from the greater longevity of general paretics, as a result of the successful methods of treating this disorder.

Table 5 presents two short time forecasts of the probable number of patients resident in the civil state hospitals on September 30, 1957 and again on September 30, 1962. On March 31, 1952, there were 86,365 patients resident in these hospitals. The probable number on September 30, 1957 will be 99,000, an increase of 12,635, or 14.6 per cent. This is based upon an average annual in-

Table 4. Patients on the Books of the New York Civil State Hospitals, June 30, 1920 and March 31, 1952, classified according to mental disorders

Mental disorders	1920 Number			1920 Per cent			1952 Number			1952 Per cent		
	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total
General paresis	1,023	342	1,365	5.8	1.7	3.6	2,433	1,126	3,559	5.6	2.1	3.7
With other syphilis of central nervous system	81	49	130	0.5	0.2	0.3	317	211	528	0.7	0.4	0.5
With epidemic encephalitis**	....	....	....	..	..	..	249	174	423	0.6	0.3	0.4
With other infectious diseases†	....	....	....	..	..	..	39	39	78	0.1	0.1	0.1
Alcoholic	1,032	467	1,499	5.8	2.3	3.9	2,677	1,035	3,712	6.1	2.0	3.8
Due to drugs or other exogenous poisons	18	22	40	0.1	0.1	0.1	36	51	87	0.1	0.1	0.1
Traumatic	38	11	49	0.2	0.1	0.1	498	105	603	1.1	0.2	0.6
With cerebral arteriosclerosis	333	281	614	1.9	0.9	1.6	3,962	4,364	8,326	9.0	8.2	8.6
With other disturbances of circulation†	....	....	....	..	..	..	92	89	181	0.2	0.2	0.2
With convulsive disorders	539	578	1,117	3.0	2.8	2.9	972	959	1,931	2.2	1.8	2.0
Senile	412	864	1,276	2.3	4.2	3.3	1,673	3,593	5,266	3.8	6.8	5.4
Involutional	234	632	866	1.3	3.1	2.3	1,152	3,557	4,709	2.6	6.7	4.9
Due to other metabolic, etc., diseases	49	117	166	0.3	0.6	0.4	58	150	208	0.1	0.3	0.2
Due to new growth	4	4	8	*	*	*	47	37	84	0.1	0.1	0.1
With organic changes of nervous system	76	74	150	0.4	0.4	0.4	312	278	590	0.7	0.5	0.6
Manic-depressive	1,187	2,480	3,667	6.7	12.1	9.6	1,127	2,856	3,983	2.6	5.4	4.1
Dementia præcox	10,653	12,055	22,708	60.0	58.7	59.3	25,172	30,812	55,984	57.4	58.1	57.8
Paranoia and paranoid conditions	574	966	1,540	3.2	4.7	4.0	301	520	821	0.7	1.0	0.8
With psychopathic personality	266	375	641	1.5	1.8	1.7	433	472	905	1.0	0.9	0.9
With mental deficiency	678	670	1,348	3.8	3.3	3.5	1,528	1,860	3,388	3.4	3.5	3.4
Psychoneuroses	82	158	240	0.5	0.8	0.6	408	560	968	0.9	1.1	1.0
Undiagnosed	467	385	852	2.6	1.9	2.2	85	72	157	0.2	0.1	0.2
Without psychosis	6	12	18	*	0.1	*	41	12	53	0.1	*	0.1
Primary behavior disorders	....	....	....	..	..	..	218	136	354	0.4	0.3	0.4
Total	17,752	20,542	38,294	100.0	100.0	100.0	43,830	53,068	96,898	100.0	100.0	100.0

*Less than 0.05.

**Prior to July 1, 1934 these were included with other brain and nervous disease.

†Prior to July 1, 1934 these were included with other somatic diseases.

Table 5. Resident Patients in the New York Civil State Hospitals, March 31, 1952, and Forecasts as of September 30, 1957 and September 30, 1962, Classified According to Mental Disorders

Mental disorders	Number			Per cent		
	March 31,1952	Sept. 30, 1957	Sept. 30, 1962	March 31,1952	Sept. 30,1957	Sept. 30,1962
General paresis	3,361	3,300	3,200	3.9	3.3	2.9
Alcoholic	2,987	4,000	4,700	3.5	4.0	4.3
With cerebral arteriosclerosis	7,708	9,900	11,800	8.9	10.1	10.7
With convulsive disorders	1,722	1,900	2,100	2.0	1.9	1.9
Senile	5,053	6,500	7,700	5.8	6.5	7.0
Involutional	3,708	4,300	4,800	4.3	4.3	4.4
Manic-depressive	3,178	2,600	2,100	3.7	2.6	1.9
Dementia præcox	50,608	57,600	64,000	58.6	58.3	58.2
With psychopathic personality	683	800	900	0.8	0.8	0.8
With mental deficiency	3,097	3,600	4,000	3,6	3.6	3.6
Psychoneuroses	600	700	800	0.7	0.7	0.7
Without psychosis	51	60	100	0.1	0.1	0.1
All other	3,609	3,740	3,800	4.1	3.8	3.5
Total	86,365	99,000	110,000	100.0	100.0	100.0

crease of approximately 2,500. The number may be expected to increase further to 110,000 on September 30, 1962. The major groups of mental disorders are all expected to share in the increase, with the exception of general paresis and the manic-depressive psychoses. Resident patients with general paresis totaled 3,361 on March 31, 1952, but may be expected to total 3,200 on September 30, 1962. Among those with manic-depressive psychoses, there is an anticipated decrease from 3,178 to 2,100. On the other hand, dementia præcox may be expected to increase from 50,608 to 64,000. Relative to the total number of resident patients, dementia præcox will decrease from 58.6 per cent of the total to 58.2 per cent.

Resident patients with psychoses with cerebral arteriosclerosis may be expected to increase from 7,708 in 1952 to 11,800 in 1962. Their percentage of the total will increase from 8.9 to 10.7. A similar increase will occur among those with senile psychoses. The latter will increase from 5,053 in 1952 to 7,700 in 1962, or from 5.8 to 7.0 per cent of the total. Together, these two groups will represent 17.7 per cent of the total patients on the books in 1962. This is less than half of their relative prevalence among first admissions. It is, therefore, of importance to note that the growing percentage of the aged among the patients on the books is due only in part to

an increase in admissions with psychoses with cerebral arteriosclerosis and senile psychoses. The great bulk of the aged are patients with dementia præcox, who have been accumulated in large numbers in the hospitals because of their long average hospital residences.

Table 6 provides forecasts for the expected number of resident patients in 1957 and 1962, classified according to age. Three trends appear to be present. Relative to the total resident patients, those

Table 6. Resident Patients in the New York Civil State Hospitals, March 31, 1952, and Forecasts as of September 30, 1957 and September 30, 1962, Classified According to Age

Age (years)	Number			Per cent		
	Mar. 31, 1952*	Sept. 30, 1957	Sept. 30, 1962	Mar. 31, 1952	Sept. 30, 1957	Sept. 30, 1962
Under 15	317	400	500	0.4	0.4	0.4
15-19	948	1,100	1,200	1.1	1.1	1.1
20-24	2,256	2,700	3,000	2.6	2.7	2.7
25-29	3,734	4,100	4,300	4.3	4.1	3.9
30-34	5,232	5,600	5,800	6.1	5.7	5.3
35-39	6,623	7,100	7,400	7.7	7.2	6.7
40-44	7,930	8,500	9,000	9.2	8.6	8.2
45-49	8,622	9,300	10,000	10.0	9.4	9.1
50-54	9,021	9,600	10,300	10.4	9.7	9.4
55-59	8,821	9,700	10,300	10.2	9.8	9.4
60-64	8,795	10,200	11,300	10.2	10.8	10.3
65-69	7,867	9,700	11,300	9.1	9.3	10.3
70 or over	15,938	21,000	25,600	18.4	21.2	23.2
Unascertained ..	231	....	....	0.3	..	..
Total	86,335	99,000	110,000	100.0	100.0	100.0

*Estimated by excluding patients in convalescent care, in family care, and on escape.

under 25 years of age will remain constant. There will be relative decreases among those aged 25 to 59. At ages 60 to 64, there is an expected increase from 10.2 per cent of the total in 1952 to 10.8 in 1957, followed by a decrease to 10.3 per cent in 1962. It is probable, however, that the latter estimate is due more to difficulties with respect to extrapolation than to a genuine relative decrease. The probability that this interpretation is correct is emphasized by the fact that the forecasts indicate great increases at ages 65 or over, both in absolute numbers and in relative proportions. Thus, those aged 65 or over will grow from 23,805 on March 31, 1952 to 36,900 on September 30, 1962, an increase of 13,000 (in round num-

Table 7. Patients on the Books of the New York Civil State Hospitals March 31, 1952, Classified According to Age and Mental Disorders

Mental disorders	Males	Total Females	Total	5 to 9 years M.	5 to 9 years F.	10 to 14 years M.	10 to 14 years F.	15 to 19 years M.	15 to 19 years F.	20 to 24 years M.	20 to 24 years F.	25 to 29 years M.	25 to 29 years F.
General paresis	2,433	1,126	3,559	..	..	..	..	7	5	7	8	19	19
With other syphilis of cen. nerv. sys.	317	211	528	..	..	..	..	2	1	1	2	7	1
With epidemic encephalitis	249	174	423	..	..	1	..	3	4	9	3	9	11
With other infectious diseases	39	39	78	1	..	1	1	4	6	5	2	3	4
Alcoholic	2,677	1,035	3,712	..	..	..	..	..	1	3	4	25	19
Due to drugs or other exogenous poisons	36	51	87	..	..	1	..	1	1	1	..	2	2
Traumatic	498	105	603	..	1	2	1	8	1	9	7	19	5
With cerebral arteriosclerosis	3,962	4,364	8,326	..	..	..	..	..	..	..	..	..	..
With other disturbances of circulation	92	89	181	..	..	..	..	..	..	1	..	..	2
With convulsive disorders	972	959	1,931	..	..	6	..	26	18	53	48	91	80
Senile	1,673	3,593	5,266	..	..	..	..	..	..	..	..	..	..
Involutional	1,152	3,557	4,709	..	..	..	..	..	..	..	..	..	..
Due to other metabolic, etc., diseases	58	150	208	..	..	..	..	1	..	2	1	1	2
Due to new growth	47	37	84	..	..	..	..	..	..	2	1	..	3
With organic changes of nervous system	312	278	590	4	1	7	2	7	8	9	10	20	9
Manic-depressive	1,127	2,856	3,983	..	1	..	..	1	4	13	20	10	53
Dementia præcox	25,172	30,812	55,984	19	3	65	40	338	307	1,076	813	1,717	1,584
Paranoia and paranoid conditions	301	520	821	..	..	..	..	..	..	..	..	2	..
With psychopathic personality	433	472	905	..	..	..	..	20	38	44	54	41	42
With mental deficiency	1,528	1,860	3,388	..	..	4	5	43	52	120	111	151	139
Psychoneuroses	408	560	968	..	..	1	..	4	8	24	34	31	50
Undiagnosed	85	72	157	1	..	1	1	2	2	4	2	1	4
Without psychosis	41	12	53	..	..	4	..	3	2	9	2	5	1
Primary behavior disorders	218	136	354	28	8	116	29	62	74	5	13	1	6
Total	43,830	53,068	96,898	53	14	209	79	532	532	1,397	1,135	2,155	2,036

Table 7. Patients on the Books of the New York Civil State Hospitals March 31, 1952, Classified According to Age and Mental Disorders—(continued)

Mental disorders	30 to 34 years		35 to 39 years		40 to 44 years		45 to 49 years		50 to 54 years		55 to 59 years		60 to 64 years		65 to 69 years	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
General paresis	28	40	70	56	199	121	348	169	472	199	435	172	366	131	272	104
With other syphilis of cen. nerv. sys.	7	6	19	13	21	19	36	22	32	35	54	34	49	29	29	23
With epidemic encephalitis	23	21	46	32	45	28	41	36	42	10	16	20	8	7	3	1
With other infectious diseases	7	2	1	3	1	2	2	3	5	5	2	4	2	3	2	2
Alcoholic	56	42	120	87	195	112	324	148	403	139	409	152	456	133	358	97
Due to drugs or other exog. poisons	1	1	2	5	3	5	4	5	5	8	4	10	11	1	1	4
Traumatic	27	7	25	5	39	10	41	10	64	7	81	13	78	9	48	10
With cerebral arteriosclerosis	..	..	1	1	1	4	13	12	45	50	151	169	467	482	882	833
With other disturbances of circulation	1	1	5	1	5	7	9	8	21	20	10	24	8	14	9	5
With convulsive disorders	110	100	128	112	113	122	114	101	90	103	66	86	72	82	62	60
Senile	..	..	..	..	..	1	..	1	1	3	..	11	35	53	126	255
Involutional	..	1	..	7	6	94	29	275	143	596	264	825	294	793	230	560
Due to other metabolic, etc., diseases	..	5	2	3	3	9	4	16	4	22	16	36	13	34	8	14
Due to new growth	5	3	1	4	2	4	7	3	6	5	5	4	10	2	2	2
With organic changes of nerv. sys.	21	30	21	25	24	28	29	30	48	43	43	36	46	24	18	17
Manic-depressive	24	77	37	153	72	243	106	318	161	367	139	438	172	385	177	320
Dementia præcox	2,248	2,418	2,809	3,090	3,238	3,523	3,190	3,647	2,844	3,507	2,248	3,349	2,041	2,999	1,564	2,296
Paranoia and paranoid conditions	2	3	4	5	12	17	14	27	33	41	41	50	44	66	59	68
With psychopathic personality	51	38	46	36	48	34	38	39	27	39	24	49	30	33	32	23
With mental deficiency	195	149	144	195	158	207	139	196	179	178	116	191	112	184	69	107
Psychoneuroses	50	52	28	74	35	78	49	54	53	47	38	39	31	43	39	23
Undiagnosed	7	8	5	5	4	10	9	6	7	8	9	12	14	3	8	6
Without psychosis	2	2	4	2	1	..	2	1	5	1	2	1	2	..	..	..
Primary behavior disorders	1	..	1	..	1	1	..	2	1	1	..	2	..	..	1	..
Total	2,866	3,006	3,519	3,914	4,226	4,679	4,548	5,129	4,691	5,434	4,173	5,727	4,361	5,510	3,999	4,830

Table 7. Patients on the Books of the New York Civil State Hospitals March 31, 1952, Classified According to Age and Mental Disorders—(concluded)

Mental disorders	70 to 74 years		75 to 79 years		80 to 84 years		85 to 89 years		90 to 94 years		95 to 99 years		100 years and over		Unascertained	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
General paresis	127	58	50	33	20	5	4	1	2	2	1	..	..	..	6	3
With other syphilis of cen. nerv. sys.	21	17	17	4	8	2	1	..	..	..	..	..	..	..	13	3
With epidemic encephalitis	2	1	..	..	..	..	..	..	..	..	..	..	..	..	1	..
With other infectious diseases	..	1	2	1	..	..	..	..	..	..	..	..	..	..	1	..
Alcoholic	188	46	101	31	31	14	5	6	1	1	..	1	..	..	2	2
Due to drugs or other exog. poisons	..	2	..	1	..	1	..	..	..	..	..	..	..	..	..	5
Traumatic	28	10	20	4	7	2	2	..	..	..	..	..	..	..	..	3
With cerebral arteriosclerosis	937	998	776	879	444	580	169	249	54	78	7	12	1	3	14	14
With other disturbances of circulation	1	2	2	3	..	2	..	..	..	..	..	..	..	..	20	..
With convulsive disorders	22	23	11	18	5	4	2	1	..	..	..	..	..	..	1	1
Senile	307	609	424	892	434	908	232	565	92	229	13	53	7	7	2	6
Involutional	125	246	43	111	16	31	1	7	..	1	..	1	..	..	1	9
Due to other metabolic, etc., diseases	..	5	1	1	..	..	..	..	..	..	..	..	..	..	3	2
Due to new growth	4	2	1	..	1	2	..	1	..	..	..	..	..	..	1	1
With organic changes of nerv. sys.	7	7	4	5	..	1	2	..	..	..	..	..	..	..	2	2
Manic-depressive	119	248	57	134	28	59	7	21	3	7	..	1	..	1	1	6
Dementia præcox	915	1,520	501	947	206	466	72	172	18	49	5	16	6	7	52	59
Paranoia and paranoid conditions	48	74	26	80	9	48	6	27	1	6	..	1	..	1	..	6
With psychopathic personality	19	22	8	16	3	4	2	1	..	1	..	..	..	..	..	3
With mental deficiency	62	77	16	45	14	14	5	3	1	..	..	1	..	..	..	6
Psychoneuroses	14	40	6	11	2	3	1	1	..	1	..	..	..	..	2	2
Undiagnosed	8	2	2	2	1	..	..	1	..	..	..	..	..	..	2	..
Without psychosis	..	..	..	..	1	..	..	..	..	..	..	..	..	..	1	..
Primary behavior disorders	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..
Total	2,954	4,010	2,068	3,218	1,230	2,146	511	1,056	172	375	26	86	14	19	126	133

bers), or 55 per cent, whereas, the total resident population will have increased by only an estimated 27 per cent. Relative to the total resident population, those aged 65 or over will have increased from 27.5 per cent in 1952 to 33 per cent in 1962. Thus, the problem of providing for the care of aged patients will grow more acute in the future.

Summary

With few exceptions, the population of the New York civil state hospitals has grown steadily. The total on March 31, 1952 was 96,898, the highest recorded up to that date. Because of their greater longevity, the proportion of females has been growing from year to year. In addition to growth in number, there has been an important change with respect to the ages of the patients. The average age grew from 48.0 years in 1915 to 53.9 years in 1952. The increase of the average age resulted from the growth of elderly patients. In 1930, for example, those aged 60 or over numbered 11,705, or 24.9 per cent of the total. In 1952, the number in this age interval had grown to 36,585, or 37.8 per cent of the total.

The change in the age distribution was accompanied by changes in the relative distribution of the groups of mental disorders. Between 1920 and 1952, the number of patients with psychoses with cerebral arteriosclerosis grew from 614, or 1.6 per cent of the total, to 8,326, or 8.6 per cent. The senile psychoses grew from 1,276 to 5,266, or from 3.3 to 5.4 per cent of the total. Despite a marked decrease in the number of first admissions with general paresis, they now form an increasing percentage of the total on the books. This is due to the great decrease in mortality, resulting from the newer methods of treating general paresis. Table 7 shows the 1952 patient population, classified according to both age and mental disorder.

An attempt was made to forecast the probable number of patients under treatment in 1957 and in 1962. Assuming a probable average increase of 2,500 per year, we may expect a total of 99,000 in 1957, and a total of 110,000 in 1962. With the exception of general paresis and manic-depressive psychoses, all of the major groups of mental disorders are expected to share in the increase. Dementia praecox will continue to be the largest group in the hospitals, because of the long average duration of the disease. The psychoses associated with old age will continue to grow, but be-

cause of their heavy mortality, patients with these disorders will remain inferior in number to dementia præcox. Those aged 65 or over will form an increasing proportion of the total population. They may be expected to grow to 36,900 in 1962, and will represent 33 per cent of the total hospital population.

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REVIVAL OF EARLY MEMORIES WITH THE APPEARANCE OF PRIMITIVE DEFENSE REACTIONS INCLUDING APHTHOUS MOUTH ULCERS, MUSCLE-TENSING, AND URTICARIA

BY RICHARD C. ROBERTIELLO, M. D.

While in analysis a patient, in reviving some incidents which must have belonged to a period that was very likely the first month of his life, became aware of certain symptoms that seemed to be the revival of primitive defense reactions which were appropriate to that era. These included urticaria, aphthous ulcers of the mouth, and muscle-tensing.

The patient is a 26-year-old, white, married student, who had been in treatment for about a year and a half. He came into treatment because of anxiety, depression and premature ejaculation. His illness had come on two years before he started therapy, at a time when he became engaged to be married and was accepted as a student in a graduate school. Up to the point in therapy where these primitive reactions came out, he had been discussing his Oedipal problem, his fear of authority, his withdrawal from facing the male assertive role and his latent homosexual defense against it.

One day he came in saying that he was very touchy and depressed. He felt unloved—"like a hurt puppy." He looked back on his relationship with his mother and thought of the tantrums he had used as a means of getting his way. He said he was beginning to alter his idea that his mother was an ideal person and was self-sacrificing. Up to this time in therapy he had always spoken of her in these terms, though he recognized he had a good deal of guilt with respect to her. He said it was distasteful for him to see his mother as anything but an ideal figure, but that he felt that he had not had too much genuine affection from her. He said that he knew he felt rejected by his mother and finally concluded at the end of the session that his depression was due to hostility toward his mother for rejecting him. He pointed out, nevertheless, that his memories of his mother were that she was a very kind, gentle, accepting person. This was one of the first situations in therapy in which pre-Oedipal material had appeared.

At his next session the patient came in and said that he had urticaria on all four extremities and on his ear lobes, that he had aphthous mouth ulcers, and had been very miserable for the past

few days. He had been thinking about his feelings toward his mother. He felt that he was not getting enough support from his environment. He had been profoundly sad. He said he felt badly about having to express his hatred toward his mother, but that he felt that he had been "jilted" as a child. He said that no one had taken any interest in him then. He reported the following dream: "I was in an enormous bus terminal. There was a huge dining hall there, all beautiful and very elaborate. I was having dinner in this beautiful place with my wife, and there were actors and actresses around. Then I left and I went to a poverty-stricken slum area in New York. There was a rough kid kicking up a fuss, rolling around the street in a box." In his associations to the dream, the patient said that this child recalled a boy he had been seeing who was very much deprived by his mother. He recalled having thought that the boy's mother was nasty, sloppy, and rejecting. He also associated to the idea of actors and actresses, an incident when he had gone into a restaurant and complained about the food and had been told that a famous Hollywood actor ate there and that *he* never complained. The dream interpretation to the patient was that the beautiful dining hall represented the breast situation and the poverty-stricken area represented the deprived feeling of having been weaned. He was told he had had this reaction of hostility toward his mother at the time of what must have been a sudden and abrupt weaning. The patient subsequently found out that his mother had had a breast abscess during the first weeks of his life and that he had been weaned abruptly at that point. He also found out that at that time he had developed a generalized rash and that he had been taken care of by an older brother.

During the patient's next session he said that he had "hit the miseries," that he had had great anxiety and that urticaria and the dream were bothering him. He connected the dream of oral deprivation and the urticaria with the rash that he had had in the first few weeks of life when his mother had the breast abscess. He then started talking about the split between his feeling and his thinking that occurred when he became anxious. He had previously been aware of this split between feeling and thinking and referred to it as a schizophrenic mechanism. He also said that when he became anxious, he stiffened and pulled his body together, tensing all the muscles centripetally as if to hold himself together. He reported another dream. "I was standing on a huge stairway. I

had a fear of height [the patient has had a height phobia all his life]. There were three people there, my wife and two other boys. One of the boys was in my class and the other was a vaguer character but a strong one. This boy in my class is nice but he is depressed and disturbed emotionally. I was perched up there. The stairway seemed to be overhanging a park. I took one step to go down but I could not follow them down. The wind blew and I thought I would fall. I withdrew and stepped back to the level I was on and got very frightened as to how I would go down. I then saw a building which I entered. The room I went into turned out to be a men's room. I felt that this part of the dream had a homosexual significance and noted that there were two doors into the bathroom."

His associations to the dream were a feeling that the kind of urticaria he had was brought on by the wind blowing and that the stairway situation recalled his height phobia. He also noted that for the last few days he had been pulling his body together, crossing his legs, and pushing his hands together centripetally. This recalled the tensing of muscles to give him the feeling of security and also a tensing of the skin which reminded him of the way a baby would try to get his skin in as much contact as possible with the mother's. At this point it was noted that the urticaria was also a skin-stimulatory experience. Then the patient was reminded that he had previously had a great many fantasies about women which dealt, not with intercourse or any oral or anal experience with them, but simply with the desire for contact between his skin and theirs. He then interpreted the dream on a genital level. He said that coming down the stairway meant intercourse, that going down one step and then returning was equivalent to premature ejaculation. Going into the men's room meant an attempt at solution of his sexual problem via homosexuality and anal regression.

It was a fact that the only way he could maintain his erection and avoid premature ejaculation was to use the *a tergo* position. In the dream, the other men were going in the front way but he was forced to go in the back way. He noted further that he could not fit the wind situation into his interpretation; and the writer asked him to try to interpret the dream on an earlier level. On this level it seemed as if his wife (mother) left him, he felt cold (the wind), and so he urinated and defecated on himself to get his skin warm and to get his brother to take care of him. It was pointed out that

the urticaria in the present situation was this primitive mechanism for re-establishing skin eroticism which he had re-established as an infant by the skin rash and by the urination and defecation. He was rather anxious and asked for an extra session the next day.

The next day he said that he had slept well and that most of his anxiety was gone. He had had a dream which had constructive elements, in that he seemed to feel free in socializing with people and also felt that he would be able to stand up to authority figures. Also in his dream, there was a muscle-eroticism situation in which he did an acrobatic stunt. He noted also in his associations with the dream that the idea of photographs came up. This recalled that he had always felt ugly and did not want ever to have photographs taken of himself. This also perhaps might have been a manifestation connected with the skin eroticism. He also noted at this point that his relationship to the writer was a very ambivalent one, that he either thought of the writer as the most wonderful person in the world or else was flooded with a group of very derogatory ideas.

It was pointed out to him that this ambivalence was the kind of ambivalence that a very young child feels toward the mother. When the mother feeds him, she becomes the most wonderful thing in the world; when she goes away from him, he feels very rejected and hostile. It was also pointed out that the split between his ideation and his affect might very likely have occurred on this early level—it was difficult for the child to face the mother's leaving, so he had to maintain the fiction of her being there to avoid the feeling of anxiety and hostility at her departure. He thought that because of his very early trauma with his mother, he had difficulty relating to people in his adult life. He noticed that he had an exaggerated need for approval and support from people and that his reactions to them varied from moment to moment depending upon whether they gave him support or rejected him. He noticed after these interpretations that he felt able to socialize better and that his urticaria improved. He also recalled that, when he was in combat, if he felt cold, he felt very frightened. If there was a blanket around him, he felt warmer and safe.

In the next interview he noted that he had been breaking into feelings of anxiety after meals and suggested that the meaning of his anxiety was a fear of being abandoned and being left to starve. He again noted the aphthous ulcers, urticaria, and the muscle-

tensing in associating to these situations. It was pointed out to him that these were very early oral eroticisms, muscle eroticisms, and skin eroticisms, that were appropriate to that era of his development and that they were coming up now when he was dealing with this early material.

From this discussion it would seem that, when a patient is bringing up material relating to a certain period of his life, some of the difficulties that will appear as a means of dealing with the anxiety are defenses that are appropriate to that earlier time of life, rather than to his actual chronological age. In the situation reported here, with the appearance of material relative to the patient's abrupt weaning and separation from his mother during the early weeks of life, three symptoms appeared—aphthous ulcers of the mouth, urticaria, and muscle-tensing. It is known that in this early period, a child's libido is fixed to a large extent on his mouth, skin, and muscles. When the patient as a child had been separated from the warmth of the mother's body and from her breast, he broke out into a rash, and very possibly may have had an increase in muscle-tensing as a means of re-establishing—through increasing skin and muscle eroticism—some of the sensation that was lost through the loss of the mother. It is interesting that, in the recall of this material, the aphthous ulcers of the mouth may stand for a revival of oral eroticisms, the muscle-tensing for a revival of the muscle eroticisms, and the urticaria a revival of the skin eroticisms, to replace the stimulation that was lost through the mother's separation.

This last observation on the psychodynamics of the urticaria may be of particular value in helping to understand the meaning of irritative skin conditions. The patient feels insecure and regresses to a very infantile level where a great deal of his security once rested in his bodily contact with the mother. The appearance of the urticaria, therefore, corresponds to the body's attempt to revive the skin stimulation that was originally derived from contiguity between the mother's and the baby's skins.

Summary

A case in psychoanalytic therapy is reported. The patient revived memories of events that must have occurred in the early weeks of his life. Coincidental with this, there appeared aphthous mouth ulcers, muscle-tensing, and urticaria. These symptoms are explained as revivals of skin, muscle and oral eroticisms—mech-

anisms he might have used as an infant in an attempt to re-establish the sensations he had lost through separation from his mother.

The psychosomatic symptoms of a patient in analysis may be appropriate to the period he is in the process of remembering. Urticaria may represent a skin-stimulating situation created to re-establish the feeling of contiguity between the skins of the mother and the child.

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THE CONTROL OF TUBERCULOSIS AMONG PATIENTS IN MENTAL INSTITUTIONS—A 10-YEAR REPORT

BY JULIUS KATZ, M. D., ROBERT E. PLUNKETT, M. D., AND HENRY BRILL, M. D.

It is the purpose of this paper to report the results obtained during the first 10 years of operation of a tuberculosis control program in the institutions of the New York State Department of Mental Hygiene. This program was begun in the fall of 1941, and includes all 27 institutions of the department, with about 100,000 patients and 25,000 employees.

Fundamentally the program consists of two phases, the early detection of tuberculosis, and the prevention of its spread by segregation and treatment. Early diagnosis is made possible by routine periodic chest x-ray examination of patients within the institutions and upon admission. Employees are x-rayed prior to permanent appointment and periodically thereafter. Segregation and treatment of tuberculous patients are provided in special buildings or in tuberculosis wards. Employees with active tuberculosis are referred to tuberculosis hospitals.

During the 10-year period following 1941, three chest x-ray surveys have been completed in all but one of the institutions, and four have been made in 15. While not strictly within the time period covered in this report, the results obtained in these 15 institutions are included in order to provide additional data regarding the trend of morbidity and mortality.

A. Tuberculosis Among Patients Before Admission

While the large amount of tuberculosis among patients in mental institutions is well known to psychiatrists and to those engaged in tuberculosis work, the high prevalence of this disease among mental patients, even before they are admitted to institutions, is probably not fully appreciated.

Among the 68,475 patients admitted or readmitted to state mental institutions in the three-year period between 1949 and 1951, 1.6 per cent were found to have clinically significant pulmonary tuberculosis at the time of admission or readmission (Table 1). The total amount of tuberculosis in the general adult population including both known and unknown cases is estimated at about 0.6 per

Table 1. Prevalence of Clinically Significant Tuberculosis Among Patients Admitted or Readmitted to New York State Mental Institutions, 1949-1951

	Total			1949			1950			1951		
	Admissions	Cases	Rates Per cent	Admissions	Cases	Rates Per cent	Admissions	Cases	Rates Per cent	Admissions	Cases	Rates Per cent
Total	68,475	1,119	1.6	23,168	351	1.5	22,584	394	1.7	22,723	374	1.6
Males	34,234	766	2.2	11,603	236	2.0	11,246	283	2.5	11,385	247	2.2
Females	34,241	353	1.0	11,565	115	1.0	11,338	111	1.0	11,338	127	1.0

cent, so that there is two to three times as much tuberculosis among mental patients even before they become inmates in institutions, as there is in the general adult population. As a result, it is obvious that, regardless of the effect of the intramural program, as long as the prevalence of tuberculosis among patients on admission remains high, the rate within the institutions must also remain higher than in the general population.

B. Tuberculosis Among Patients Within the Institutions

1. *Prevalence of Tuberculosis*

At the time of completion of the first survey in all the mental institutions, 4,548 cases of clinically significant tuberculosis were found among the patients. By the time the second survey was completed, four years later, the number had decreased to 3,255; and the third survey, completed four years after the second, disclosed 2,335. Thus there was a decrease of more than one-fourth in the number of cases of clinically significant tuberculosis between each of the surveys. For the total period, the decrease in prevalence was more than 50 per cent (Table 2).

Table 2. Prevalence of Clinically Significant Pulmonary Tuberculosis Among Patients in New York State Mental Institutions in Each of the Three Chest X-ray Surveys

	First survey		Second survey		Third survey	
	Number	Per cent	Number	Per cent	Number	Per cent
Total	4,548	5.1	3,255	3.5	2,335	2.3
Males	2,518	5.9	1,918	4.3	1,411	3.0
Females	2,030	4.4	1,337	2.7	924	1.7

There are several possibilities to be considered in explaining the decrease:

1. If fewer cases of tuberculosis were admitted to the institutions, other conditions remaining the same, the total number would decrease after a few years. Since there has been no significant change in the amount of tuberculosis among patients on admission between 1949 and 1951 as shown in Table 1, the decrease is not due to any change in prevalence among newly-admitted patients.

2. Again assuming that other conditions remain the same, any change in the tuberculosis death rate affects the number of cases of tuberculosis, an increase in the number of deaths resulting in a decrease in the number of cases, and vice versa. The tuberculosis

death rate in mental institutions has been decreasing since 1943 (Table 3), so that this can be excluded as a cause of the decrease in prevalence.

Table 3. Tuberculosis Deaths and Death Rates Per 100,000, for Patients in New York State Mental Institutions, and for New York State, 1935-1951

	Mental hospitals			N. Y. State		
Year	Number of deaths	Rate per 100,000	Per cent change from prev. year	Number of deaths	Rate per 100,000	Per cent change from prev. year
1935	466*	623.6	..	7,265	55.6	..
1936	482*	623.1	— 0.1	7,477	56.9	+ 2.3
1937	546*	675.3	+ 8.4	7,171	54.2	— 4.7
1938	462*	555.2	—17.8	6,403	48.1	—11.3
1939	496	580.7	+ 4.6	6,353	47.4	— 1.5
1940	505	574.5	— 1.1	6,095	45.1	— 4.9
1941	536	607.2	+ 5.7	6,111	45.0	— 0.2
1942	574	639.7	+ 5.4	5,976	43.7	— 2.9
1943	659	744.6	+16.4	6,281	45.5	+ 4.1
1944	622	710.0	— 4.6	5,997	43.0	— 5.5
1945	521	590.9	—16.8	5,907	42.1	— 2.1
1946	513	571.4	— 3.3	5,525	38.9	— 7.6
1947	444	485.6	—15.0	5,214	36.2	— 6.9
1948	461	490.3	+ 1.0	5,078	34.7	— 4.1
1949	377	390.4	—20.4	4,389	29.8	—14.1
1950	310	308.6	—21.0	3,772	25.4	—14.8
1951	260	252.4	—18.2	3,464	22.9	— 9.8

*Estimated.

3. The change in rate of discharge of tuberculous patients from the institutions during the period of the program is probably not large enough to affect the prevalence of tuberculosis materially.

4. More effective specific treatment of tuberculous patients, resulting in more patients reaching a state of apparent cure of their disease, would result in decreasing the number of clinically significant cases. This is not, however, considered the cause of any considerable decrease, since collapse therapy is used only to a small extent, while the effect of the use of antibotics has probably not yet become sufficiently manifest to affect the prevalence.

5. Any decrease in the rate of development of new cases (incidence rate) would result in a corresponding drop in the total number of cases. This is considered the most important cause of the decrease in the number of clinically significant cases, and will be considered in some detail.

2. *Incidence of Tuberculosis*

The term "incidence" is used to indicate the rate of development of new cases of tuberculosis *within a given period,* usually on an annual basis. Accordingly, in discussing incidence, the rates obtained in the interval between the first and second surveys, calculated on an annual basis, will be used as a basis for comparison with annual rates obtained subsequently.

In the interval between the first and second surveys of the institutions of the department, there was an annual incidence rate of 4.8 new cases per 1,000 patients, or almost one-half of 1 per cent. There is no accurate information regarding the annual incidence rate in the general population of the state, but it is estimated at about 1 per 1,000 population over 15 years of age for the period between 1941 and 1948. The rate among mental patients was, therefore, about five times as high as that of the general population. The incidence among male patients was almost twice as high as that among females (Table 4).

Table 4. Annual Tuberculosis Incidence Rates Among Patients in New York State Mental Institutions

	Incidence rates per 1,000			Decrease in incidence rates (per cent)		
	Period between first and second surveys	Period between second and third surveys	Period between third and fourth surveys*	Betwen second and third surveys	Betwen third and fourth surveys	Between second and fourth surveys*
Total	4.8	2.8	1.9	—41.7	—32.1	—60.4
Males	6.2	3.8	2.7	—38.7	—28.9	—56.5
Females	3.4	2.0	1.2	—41.2	—40.0	—64.7

*Fifteen institutions only (see text).

Between the second and third surveys, the average annual incidence rate was 2.8 new cases of tuberculosis per 1,000, a decrease in this rate of 42 per cent. The decrease in rate was somewhat greater among females (Table 4).

For the 15 institutions surveyed four times, the average annual incidence rate shown by the fourth survey was 1.9 per 1,000. In comparison to the rate of 2.8 obtained at the time of the third survey of all institutions, this represents a decrease in rate of 32 per

cent. Since the second survey, the decrease for these hospitals was 60 per cent.

The cause of this decrease in incidence rate is probably the earlier diagnosis and segregation of infectious cases among these patients. This explanation is more easily understood when conditions existing prior to the beginning of the program are recalled. At that time, although most institutions had tuberculosis wards, almost every other ward in every institution—because of the lack of adequate case-finding facilities—contained patients with undiagnosed tuberculosis, who acted as foci of infection for the rest of the ward residents. As a result, there were more cases on the general wards of the institutions than in the tuberculosis wards. The periodic chest x-ray surveys, and the routine chest x-ray films taken on admission, by uncovering these hitherto unrecognized cases, and making possible earlier segregation, broke the cycle of infection and exposure, thereby reducing the number of newly-developed cases. In spite of the very considerable decrease, however, mental patients still develop tuberculosis about twice as frequently as do other residents of the state.

3. *Segregation of Tuberculous Patients*

Before the program began, most institutions had special wards for tuberculous patients. The original plan in this program called for the concentration of all tuberculous patients in a few institutions. As of June 1, 1952 there are no tuberculosis wards in 13 institutions; the tuberculosis wards at four are currently in the process of elimination; there are tuberculosis wards in buildings housing nontuberculous patients at four; and there are separate buildings for tuberculous patients available at six.

Until recently, emphasis was concentrated upon the segregation of cases of clinically significant tuberculosis. However, the need for segregation of patients with inactive disease must also be considered, because of the relative frequency of reactivation of the disease among these patients. No accurate data are yet available regarding the rate of reactivation; but preliminary studies indicate that at least for the first few years after the disease reaches a state of apparent cure, the rate is approximately 2 per cent of these patients annually, a rate sufficiently high to make this an important problem. Present plans call for the segregation of cases of inactive disease in separate wards for two years before they are

returned to the general wards. These plans may require revision as more data regarding reactivation of healed disease become available.

4. *Treatment of Tuberculous Patients*

Until the antibiotic drugs became available, the treatment of tuberculous mental patients consisted mainly of bed rest. Pneumothorax is used to some extent, and chest surgery is done occasionally. At present there is a steadily increasing use of antibiotic therapy for these patients.

5. *Deaths from Tuberculosis*

From 1935 to 1941 the tuberculosis death rate among patients in mental institutions showed no definite trend, usually fluctuating between 600 and 700 deaths per 100,000 patients. With the beginning of the tuberculosis control program in the fall of 1941, the rate increased considerably. This sharp increase may have been due to the disclosure by the initial x-ray surveys of the large number of hitherto unknown cases, so that the diagnosis of tuberculosis as the cause of death was made more frequently. Since 1943 the death rate has been decreasing, the decrease comparing favorably with that of the state as a whole (Table 3).

A word of caution must be entered regarding the comparison of the tuberculosis death rate among mental patients with that in the general population. In calculating these rates, the number of deaths per 100,000 mental patients is compared with the number of deaths per 100,000 of the general population of the state. It is well known that tuberculosis death rates are higher in older age groups, especially among males. Since the average age of patients in mental hospitals is about 53 years,* while that of the general population of the state is about 35 years, it is obvious that any such comparison is misleading, in that it tends to exaggerate the tuberculosis death rate among mental patients relative to that in the general population. Only by comparing rates for similar age and sex groups, can the relative rates be determined with some degree of accuracy.

Since specific measures for the treatment of tuberculosis, such as pneumothorax and surgery, have been used only to a minimal

*Malzberg, B.: A statistical study of patients in the New York civil state hospitals, April 1, 1950. PSYCHIAT. QUART. SUPPL., 26:70-85, Part 1, 1952.

extent, and antibiotics have not yet been used sufficiently long and upon large enough numbers of patients to affect the death rate, the death rate decrease is probably not a reflection of improvements in therapy. Although it may be due to a reduction in the virulence of the tubercle bacillus, or to increasing resistance of the human host to this organism, a more probable cause is the decrease in the rate of development of new cases. Thus, the early diagnosis and segregation of patients with tuberculosis, resulting in decreased opportunity for exposure, not only results in reducing the number of new cases, but also thereby affects the death rate.

Summary

1. The results of the first 10 years of operation of a tuberculosis control program among patients in the institutions of the New York State Department of Mental Hygiene are reported.

2. This program consists fundamentally of the early detection and early segregation and treatment of cases of tuberculosis.

3. There has been a considerable decrease in morbidity and mortality from tuberculosis during the 10 years covered by this report, but the rates in the mental institution population are still higher than in the general population of the state.

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ELECTRIC CONVULSIVE THERAPY FOLLOWING PREFRONTAL LOBOTOMY

BY ELSE B. KRIS, M. D.

This is a report of electric convulsive therapy applied to patients after a prefrontal lobotomy had been performed. In a large series of lobotomy cases, some of the patients who had shown initial improvement shortly after psychosurgery gradually became disturbed again, started to eat poorly and were subject to distressing hallucinations. As these symptoms persisted, electric shock therapy was resorted to. Some of these patients who, before the operation, had failed to respond to electric convulsive therapy, or who were unable to maintain improvement for any length of time, showed, after the operation, surprisingly good response and were now able to maintain this improvement. All the postlobotomy patients tolerated the convulsive therapy very well, but showed the onset of a confused state earlier than usual in the course of treatment, a reaction similar to the development of confused states in elderly patients or in shock-treated cases of organic psychosis. The average course consisted of not more than 15 treatments. The following case histories will illustrate the results obtained.

Patient M. F.

Very little is known about the patient's childhood and early development. She was born in Europe and came to the United States at the age of 21. She worked as a housekeeper and got along well. At 38, she became interested in a man whom she married after one year of courtship. However, shortly after the wedding, she found out that he was very stingy, could not get along with him, and separated from him a year later—before she gave birth to twins.

One of the babies died; the other was placed in a foster home so that the mother was free to take up work in a candy factory, thus supporting herself. In 1945 she underwent a hysterectomy, after which she could not hold a job, was emotionally unstable and early in 1947 became overactive and overtalkative. She finally had to be hospitalized in March 1947. On her admission to Pilgrim (N. Y.) State Hospital she was overactive, un-co-operative, did not eat. She stated that she could hear people talking about her, telling her that her husband had married another woman. She received a course of 20 electric shock treatments, but failed to show any re-

sponse to this therapy and was on the verge of physical exhaustion, continuously losing weight. In August 1947 a prefrontal lobotomy was performed, following which she became quieter and better adjusted. This improvement lasted, however, for less than a month. She again became disturbed and again required tube feeding.

Six weeks following the prefrontal lobotomy electric shock therapy was resorted to. After the fourth treatment there was marked improvement, and treatments were discontinued in November when she had received nine. She made an excellent adjustment, was pleasant, well controlled, free of hallucinations, became actively interested in ward activities, and was free of active psychotic content. She was able to maintain the improvement this time and was released from the hospital toward the end of December 1947. She adjusted very well outside the hospital and was discharged a year later, working and supporting herself at the time of her discharge and up to the present.

Patient G. E.

G. E., who was born in 1908, is described as a normal child, who started to attend school at the age of six, was an average student, well liked by her teachers. She was a very quiet child, a poor mixer who had only a few friends. After finishing the twelfth grade she took a two-year course in designing and sewing and was then employed as a seamstress in large stores. In 1937 she married after one year of courtship, and stopped working in order to be able to take care of her household. Her married life is described as happy with a satisfactory sexual adjustment. In 1941 she gave birth to a healthy child.

Following the birth of this child, she was absent-minded, forgetful and began to hear voices telling her that they were going to take the baby away from her. She also started to hear God's voice, became subsequently very disturbed and finally had to be hospitalized in March 1942. She received a course of electric shock therapy with some improvement and was released from the hospital in August of the same year. At home she made a marginal adjustment until June 1946 when she again became disturbed, was afraid to let her child play outdoors and became over-religious. She kept washing her clothes constantly, complaining about being hypnotized, and finally had to be hospitalized again. On this second ad-

mission, she had a course of insulin shock therapy with 40 deep comas, showed considerable improvement and was released from the hospital in September 1946. However, she did not adjust well at home and was returned to Pilgrim State Hospital in November of the same year. On her return she was very disturbed and uncooperative, with frequent assaultive episodes. Symptomatic electric shock therapy had very little effect, and in October 1947 a prefrontal lobotomy was performed.

Following the operation, G. E. was much quieter and better adjusted, but two months later she again became very disturbed, hallucinating vividly. She could hear people talking about her, calling her bad names, she could hear the Lord telling her to kill people, she could see and feel snakes all over her body. These hallucinations were most distressing to her, and feeding or bathing her became a problem. A course of postoperative electric shock therapy was, therefore, started; and following her fifth treatment, she showed marked improvement. She no longer complained of her previous hallucinatory experiences, was quiet, well controlled and co-operative. She had a course of 15 treatments and maintained her initial improvement. Following termination of the treatment, she continued to make a very favorable adjustment. She was pleasant, compliant, showed interest in the various ward activities, mingled freely with the other patients on the ward and remained free of her previous psychotic symptoms of which she had no recollection at all. Her emotional adjustment was good, and seemed stable. She was released from the hospital in March 1948 and discharged a year later. After her return home she was able to take care of her household and her child and is said to have made a good marital and social adjustment.

Patient R. G.

This patient, who was born in New York City in 1916, is described as having been a very quiet and shy child. After leaving school at 16, she started to work as a clerk in a clothing store. She had only a few friends and did not go out very much. In 1944 she began to have depressed episodes, was unable to hold a job for any length of time and hardly talked at all at home. In 1946 she was taken to a private psychiatrist who gave her several electric shock treatments. She showed some improvement in response to this therapy, but maintained it for only a short time. In April 1948

she had to be hospitalized. She received 30 electric shock treatments with some temporary improvement. She had been mute and became so again, but before she did so, there was a short time during which she was observed talking to herself. She told the examiner at that time that people were talking about her, that they said she was a bad girl, that she did not deserve to be fed. She quickly relapsed to complete mutism and refusal of food.

A prefrontal lobotomy was performed in October 1948. Following the operation, R. G. was pleasant, co-operative, ate well, showed interest in the various ward activities and did some work during occupational therapy hours. However, this improvement did not last long, and toward the middle of December 1948 she again became mute and stopped eating completely. A course of electric shock therapy was started, consisting of 14 treatments. She showed good response to this therapy and this time was able to maintain the improvement. She made an excellent adjustment, was in good contact, pleasant, sociable, cheerful and free of psychotic symptoms. She was released from the hospital in April 1949 and shortly after her return home found a job and has been working ever since.

* * *

While not all the patients who were re-treated with electric shock following prefrontal lobotomy showed such striking and lasting improvement, this therapy always controlled episodes of disturbed behavior, mutism and distressing hallucinations, and made the patients more comfortable and less tense. As they started to eat better, their physical condition also showed considerable improvement. When carefully administered at well-spaced intervals this therapy was found to be a valuable, well-tolerated modality in the aftercare of patients following psychosurgery and was beneficial in cases which had failed to respond to electric convulsive treatment before the operation.

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A STUDY OF THE CHANGING ROLE OF THE PSYCHIATRIST IN THE STATE HOSPITAL

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Introduction

During the past few years, a gradual change has taken place in the role of the psychiatrist in the state hospital. Utilizing the techniques of group therapy and the increased knowledge of interpersonal relationships involving personnel and patients, the psychiatrist has approached the problem of dealing with an assigned hospital area as a total social setting. Considering this, the author hopes to demonstrate a changing approach to ward management, rather than to recommend a specific ward program in this paper. First, however, it may be advisable to contrast the approach used in this project with the more traditional methods.

In most state hospitals, it has been the custom to assign a psychiatrist to a ward or building with the total administrative and therapeutic responsibility for that area. In most cases, the physician used to function in his area as a sort of overlord who considered his task completed when, after making rounds or interviewing his patients, he gave orders for privileges, medicines, or specific therapies to his chief nurse or attendant. He rarely attempted to alter the social milieu of the area and seldom worked directly with, or trained, his attendant personnel. His relationship with his personnel was generally that of a master who might or might not have been respected, but who was rarely accessible.

More recently, many psychiatrists have been attempting to do individual psychotherapy with a few selected patients. Often the result of this was the unhappy feeling of the therapist that he was trying to bail out an ocean with a bucket, and the equally unhappy feeling of the attendants who didn't know how to cope with the administrative problem that the patient so singled out by the doctor presented to them. Within recent times, the physician also may have attempted some form of orthodox group therapy with his patients. In more chronic or disturbed areas, these attempts have frequently been abandoned.

This paper presents one example of how the psychiatrist improved his role, in terms of both therapy and administration, by approaching his ward as a total social situation with a constantly present dynamic interplay involving all the personnel and pa-

tients. In the program described here, the doctor was able, by understanding and utilizing the knowledge of the interpersonal relationships among himself, the chief nurse, attendants and patients, to carry out not only his administrative responsibility, but to serve as an active participant in a well-organized treatment team with agreed-upon objectives and methods. The methods used in establishing this program were based on the particular needs in the situation and were determined by the doctor's feelings concerning the type of group approach that would be most applicable. These methods included the development of a workable relationship between the physician and the nursing personnel; the maintenance of good communication between all members of the personnel group; careful evaluation of the resources available within the hospital in terms of personnel and material; and constant observation of the patients in reference to their ability to function in a group set-up. The type of program which was finally established was based on the physician's opinion that the personnel could enter into a therapeutic relationship with the patients most effectively by participating with them in ward work and recreational activities. It was also the doctor's feeling that it would be best to work with the natural groupings of patients observed on the ward. The objective of this program was to change the situation in a way that would provide the maximum opportunity for ego integration.

The Ward at the Beginning

"A" ward was located in the admission building and was intermediate between the disturbed admission and convalescent female wards. The 45 patients on "A" ward could be divided into approximately one-quarter young schizophrenics, one-quarter middle-aged patients (mostly of the involutional type), one-quarter seniles, and one-quarter patients receiving insulin coma treatments. Of the total number, almost one-half were chronic patients. Although the ward did have a constantly changing population, many of the patients had remained there for periods ranging from five to six years.

The personnel consisted of a graduate nurse, a charge attendant for each shift, psychiatric aide students and attendants.* The at-

*The registered nurse was a recent graduate who had received no special psychiatric training. Of the other members of the ward personnel, only the aide students had received any instruction in dealing with mental patients.

mosphere of the ward was one of cold, sterile cleanliness. The personnel worked hard, had a certain amount of prestige-drive, and were neither indifferent nor apathetic. Their time was spent in maintaining a clean, neat ward in which the beds were made, the floors scrubbed, the patients' clothing properly labeled and checked. The routines of awakening, bathing, and feeding the patients, were followed with reasonable care. Physical and medical needs were attended to, and the appearance of the patients was clean and neat, although little real dressing-up ever occurred. The pervading philosophy seemed to be that in doing these tasks, the personnel were completely fulfilling their duties. The ward was considered satisfactory as long as it was clean and the patients were not disturbed. When attendants were not busy taking care of household tasks and shunting patients around to the infirmary, the doctor's office, O. T., etc., the personnel grouped in the office for a cigarette and a chat. They seldom remained on the ward with the patients. Since they had had no training in actually working with patients, they would have been uncomfortable if forced to spend their time on the day porch. The chief concern of the nursing personnel centered around the insulin unit, which they knew was a potential danger area. Because their training in dealing with insulin patients was negligible, their anxiety caused them to focus their attention on this group.

The patients spent the major part of every day on the porch or in the hallway. Since "A" ward was a generally quiet ward, really disturbed patients were not allowed. It was apparent that the acceptable behavior for a patient was to be quiet and not too demanding. Sedentary inertia was the order of the day, and the patients quickly slipped into this pattern. Rarely talking to one another, they could be seen arrayed on the porch, each in her own cocoon. Occasional hostile outbursts of psychotic verbalizations would occur. There seemed to be a tension level which rose gradually out of the quietness. Eventually it would burst forth in disturbed behavior by one or more patients and then be dissolved until the tension began to increase again. Some of the patients helped with the ward tasks, but these were the same patients repeatedly, and this became a part of the established routine. Order, cleanliness and quietness were the major objectives of ward management with little thought given to the therapeutic considerations of everyday hospital living.

Laying the Groundwork

To mold a treatment team, the psychiatrist's first task was to develop a working relationship with the nursing personnel. It was necessary for him to establish himself as their trusted leader before they were able to give up traditional methods and accept his leadership in new approaches to ward management. To accomplish this objective, the physician had of necessity to spend a great deal of his time on the ward. He attempted to make informal, friendly contact with the attendant and aide groups by working closely with them. Their response to this was cautious and distant at first, but after several months they were able to feel more relaxed with the doctor. In addition to this general approach, the doctor supported and used the existing structure of ward hierarchy. He had meetings with the nurse in which he served as a teacher, and during which he encouraged her in her role of nursing leader. At the same time, regular weekly meetings were held with the nurse and charge attendants, during which problems of patients and personnel were discussed from a dynamic point of view. The work of the physician in improving the function of the insulin unit also contributed significantly toward the development of a good working relationship. The physician early recognized the anxiety of the nursing staff concerning handling of insulin patients, and, therefore, spent considerable time teaching them about insulin and improving the mechanical functioning in the unit.

As the physician's attempts to establish a treatment team, with himself as leader and the nurse as chief assistant, became more successful, he began to face the problem of helping the personnel as a whole to understand and accept their new role in the total social setting of the ward. The physician made it clear that he saw the function of the personnel as assisting patients toward recovery, and that providing a clean environment was only a small part of accomplishing this purpose. The forming of therapeutic interpersonal relations with patients was a more important aspect of the work. The doctor encouraged the initial attempts to spend more time with patients and supported the nurses in their efforts to relax the old standards of sterile cleanliness.

The increased efforts on the part of the personnel to work with patients, brought forth many questions concerning the type of relationship that was desirable. During discussions led by the physician, the extent to which relationships with patients were thera-

peutic was delineated, and it was pointed out in open discussion when these relationships crossed this boundary into the satisfaction of the personnel's own needs.

The physician knew that to insist that nurses work closely with the patients would be anxiety-producing unless he helped them with techniques of approaching patients. On many occasions, he outlined in detail the methods of approaching patients, such as asking them to get up in the morning, or to perform some specific task. For example, in asking a patient to help with the ward work the physician suggested that the patient be told that "we want you to help us, we appreciate your help, we consider your help as part of your treatment, and, if possible, the nurse will take part with you in some recreational activity when the work is finished."

The physician stressed the fact that he did not expect the nurses to understand fully or be completely comfortable with the group interplay of patients at a psychotic level. However, by participating with patients in ward work and in recreational diversions, the interplay that concerned these realistic activities of everyday life was far more intelligible and utilizable in terms of treatment.

In all of his contacts with the personnel, the psychiatrist stressed the need for communication between all the members of the therapeutic team. He himself was not only willing to share ideas and information with them; but, in turn, their observations about patients were of extreme importance to him. Their constructive suggestions could lead to improvement in ward management, and the airing of their dissatisfactions was necessary to keep everyone functioning as a team.

At this point, the physician began to explore the way in which patients grouped themselves on the ward. As a result of spending considerable time observing the patients and talking with the personnel, he noted four groups which, although loosely structured, had definite dynamic interaction. The most obvious of these was that formed by the sedentary, depressed, middle-aged women. These people occupied the same chairs on the day porch each day. They talked among themselves and seemingly were the only patients who shared their feelings with one another. Their conversations, however, consisted primarily of whining complaints. One section of the porch belonged to these women, and other patients entering this area were regarded by them as intruders. Another group occupying the same seats each day was made up of the

senile patients. Members of this group did not communicate verbally with one another, and each of the individuals seemed to have, for the most part, an isolated life. They regarded anything but routine behavior as an unwelcome change and considered music or dancing to be frivolous and objectionable behavior. The third group, which was the most disorganized of all, was that of the young patients. Rather than forming a solid front, they either remained on an individual basis or divided into small subgroups. These subgroups fluctuated frequently, the members shifting their allegiance from one to another in constant hostile power struggles. The fourth group was an artificial group made up of patients receiving insulin coma therapy. Generally, they entered into ward dynamics as participants in the young group mentioned. Many of the subgroupings began in the insulin room and continued when the patients stopped insulin.

It was noted that each group had a characteristic level of ego-functioning in respect to available occupational and recreational facilities. For example, it was observed that the more complicated organizational work, such as preparing for and cleaning up after meals, could be accomplished by the young patients, whereas the senile patients were capable of doing only the simplest tasks. It was also possible to estimate the number of personnel that would be needed to supervise a given activity.

Having organized a therapeutic team involving all of the personnel, and having equipped himself with information about the patients' natural groupings and their levels of ego-functioning, the psychiatrist formulated a group program for the ward. The patients were to be divided into a young-active, a middle-aged, a senile and an insulin group, and a psychiatric aide student would be assigned to work with each group. The aides' work would consist of two main parts: (a) getting the patients to perform the routine and necessary ward tasks in accordance with their abilities; (b) aiding and encouraging the patients to engage in supervised and organized recreational activities in accordance with their desires and interests, and within the limits of the hospital's facilities. The physician would continue to deal with the administration of individual patients in terms of privilege (ground parole, week-ends home, etc.) by direct doctor-patient interviews. The aide, working under the nurse, was to confine herself to administration of the group in terms of group activities (household duties,

ward parties, etc.). All decisions were subject to final approval by the doctor, but each aide would have considerable latitude in handling her group.

The institution of a program which so radically departed from long existing routines necessitated intensive "selling" to the personnel. After regular consultations with the nurse, the physician presented an outline of the plan to the charge attendants at their regular weekly meetings, and then to the psychiatric aide students at separate meetings. He emphasized that the program would make it easier for them to enlist patients' help with ward housekeeping. They would, therefore, have more time to join patients in recreational activities. The key selling point was less drudgery for them, and more prestige-laden functions as good psychiatric nurses. Since the aide students were to assume the main role in the program, the physician agreed to meet with them weekly to discuss any problems they might have with their groups. The real impetus behind these selling points, however, was the physician's enthusiasm, which he attempted to transmit to all of the members of the ward personnel.

A less intensive initial selling effort was made with the patients. A meeting was held with both the young-active and middle-aged patients during which the physician outlined the new program and introduced each group to its assigned psychiatric aide.

The Program

The program will be described first in relation to the groups themselves, and then from the standpoint of the role the physician played in its organization.

Young-Active Group

To the young-active group, was assigned the care of the dining room, television room and the doctor's office. Specific tasks were relegated to individual patients. The aide in charge worked out the assignments and rotated them as often as necessary to fit the needs of the job and the desires of the patients. Recreational activities were organized in as specific a way as possible. A member of the recreational department was able to help with these activities one afternoon a week. When possible the patients played softball and volleyball out of doors. When these activities were not feasible, group walks or on-the-ward games were organized.

The patients made visits to the library once a week and attended band concerts in the auditorium. The aide held weekly meetings lasting from a half-hour to an hour with this group during which complaints about work and plans for recreational activities were discussed actively. The aide attempted to bring into the discussions specific difficulties the patients met in working together. Many constructive suggestions were made and followed through by members of this group.

Middle-Aged Group

The care of the linen room, bathroom and dormitories was assigned to the middle-aged patients. Their recreational activities included occasional volleyball games, working in the flower beds, group walks and indoor games. As with the young-active group, the aide held weekly meetings similar to those already described.

Senile Group

With the senile group, the initial psychiatric objective was to encourage the patients to do as much as possible for themselves. The aide was attentive to the individuals' personal hygiene, and most of her time was involved in this type of work. Members of this group were encouraged to do simple tasks such as emptying ash trays, watering the flowers, sweeping the floors and helping to care for one another. Nothing more specific was attempted at first. Later a simple form of group meeting was organized. This meeting was patterned somewhat after a tea party, with the aide acting as "mother." The patients were gathered together, and milk and cookies were served in a friendly atmosphere. Shortly thereafter, bingo parties were held for this group.

Insulin Group

The aide assigned to the insulin group worked under the supervision of the charge attendant of the insulin unit and therefore did not have primary responsibility for these patients. However, in a limited way, it was possible to organize a program generally similar to those already described. Patients were responsible for making their beds and for maintaining the general cleanliness of the insulin unit. They were constantly encouraged to help each other as much as possible. Group walks were undertaken frequently, and ward game activities were used often.

* * *

During the initial stage of the program, the physician took a very active part in the detailed planning. He assigned the patients to their groups and kept in close touch with day-to-day programming. As noted before, he and the nurse held weekly meetings with the charge attendant group and with the psychiatric aide student group. He occasionally sat in on the weekly meetings of the aides with their patient groups and attended the monthly parties. Although he always remained available for day-to-day consultations with the personnel, he gradually was able to delegate authority more and more. However, before this was possible, it was necessary for him, personally, to smooth out many difficulties.

The most obvious problem and one of the most important was the growing chasm between the student aides and the attendants. The aides who, prior to establishment of the group program, had functioned on the ward as quasi-attendants could no longer serve in that capacity. They now had specific tasks in connection with their work as patient-group leaders. The attendants, though in reality released from many of their previous housekeeping duties, were now required to attend to the old jobs of carrying messages, procuring ward supplies, etc. . . . Thus they were denied the high, prestige-laden activity of maintaining the neatness of the ward, without having tasks of equal value in their eyes to replace their previous functions. In addition to this loss, the attendants were frequently forced to fill in as temporary group leaders when the aides went to classes. Substitute work of this sort diminished their feelings of prestige even further. This situation resulted in a definite change in the relationship of the attendants to the physician. The physician tried, at first, to deal with this problem through the regular, established meetings with the charge attendants. In these meetings, he attempted to clarify the different functions of ward personnel members and to lend weight to the prestige value of the attendants' part in the program.

This, however, was not sufficient and their resistance to the program revealed itself in numerous ways. The first of these was that the previous warmth of relationship between the attendants and the ward physician cooled considerably and the frequency of their emotional upsets increased. The most obvious occurrence, however, was that in spite of every effort on the doctor's part to the contrary, the attendants would scrub the floors or do other household activities after these had been done by the patients. In-

terestingly enough, the same attendants who had been able at first to relax their extremely high standards of cleanliness now began to complain of what they previously had been able to accept. Along with this, a routine procedure—the bathing of the patients—suddenly became the focus for all of this feeling. This particular procedure took on enormous significance as a problem in ward management and became highly endowed with feeling on the parts of both the attendants and the aides. The attendants claimed that they did not object to the program *per se* but to the fact that the aides were not giving the patients a sufficient number of baths and that the baths that they did give were interrupted when the aides went to class leaving the attendants to finish the work. The aides could not see the existence of any problem and maintained that the attendants ought to complete the remaining baths after the aides had left the ward for classes. This problem "mushroomed" up to a major battle involving the supervisory nursing personnel of the whole unit, where similar divisions of opinion occurred. At first, an unsuccessful attempt was made to handle this problem through the ward nurse. Finally, the specific problem of the bathing routine and the general underlying problems of resistance to the program were handled by multiple methods which included: (a) the beginning of weekly meetings between the nurse and the whole attendant group; (b) the working out of a complete, formal bathing routine which was practical and agreeable, in the planning of which it was necessary for the ward physician to participate actively; (c) the transferring of one of the more un-co-operative attendants to another assignment; and (d) the elimination of the confusion caused by the aides' class hours by careful planning and programming on the part of the ward nurse.

Results of the Program

Changes in the Groups

The young-active group which had always been the most discordant and difficult to manage, became much easier to deal with from both the medical and nursing standpoints. These patients seemed to be aware that someone was interested in helping them. They were able to work together on their assignments so that the ward duties were always accomplished. The amount of group interhostility never reached the point where it could not be handled within the structure of the program. Verbal arguments became

the order of the day rather than assaultive behavior. The group came forth with many suggestions of improved methods for doing the work. Likewise, the members were rather active in suggesting new recreation projects. Rejections by the staff of patients' suggestions that were good but not feasible in the hospital set-up were tolerated with a minimum of sulking and discontent. Recreational and social events that had been impossible for some individuals to participate in before, were now possible for the whole group. This group seemed to have received real support from the awareness of the staff's desire for them to participate in enjoyable activities and, through this support, they were able to achieve a more realistic attitude concerning what it was possible to do within the hospital structure.

The middle-aged group had always presented the psychiatric problem of sedentary, somaticizing, involutional individuals. They were generally apathetic and rarely spoke at any meeting. When new patients were transferred to the ward, they usually joined the already existing sitters, and dislodging them was always difficult and frequently impossible. With an organized work and recreational program, new patients did not get a chance to be as sedentary and become as hospitalized as they previously had. They were immediately absorbed into the existing norm of increased activity. As a whole, this middle-aged group made considerable progress in all respects. They began to feel more comfortable in group meetings and to speak more freely. Likewise, it became the accepted practice for all of these patients to attend occupational therapy, and, where previously the majority of this group had been bench warmers, they were now mobile most of the day. At first this group was threatened by the recreational aspect of the program. They seemed to derive most of their support from doing familiar household tasks. However, after a while, they cautiously began to engage in the recreational activities and were able to drop the "blues" and enjoy themselves for increasing periods of time. The major observation concerning this group was that these patients passed through "A" ward to the convalescent ward more rapidly than they had prior to establishment of the program.

The most obvious change in the senile group was the improvement of their personal hygiene and general appearance due to the attentiveness of the aides. Moreover, it was found that the previous tendency toward general deterioration decreased. Eventually

some of the members of this group were able to help with the simple tasks on the ward. The degree of brightness that was possible for these people in their "tea parties" was surprising, and their ability to play bingo was remarkable. No longer was this group in any way an eyesore, and it is felt that this fact had real meaning for the ward as a whole.

The insulin-therapy patients were never able to function as a truly integrated group, because their levels of ego intactness were too varied. However, to a limited degree they began to help one another and to work together in the care of the insulin dormitory. This mutual helpfulness had a prestige value within the unit, because as the patients' condition improved they were able to participate more fully in this type of approved activity. The pressure which the personnel exerted toward group co-operation was of necessity very limited.

General Changes

The appearance and atmosphere of the ward altered considerably as the program progressed. The former tension-ridden, quiet disappeared almost entirely and patients carried on rather active conversations among themselves. Verbal arguments were more frequent, but the previously occurring high-tension, aggressive outbursts were relatively rare. On the physician's ward rounds, it was possible to converse more freely with many of the patients, since their attitude of withdrawn suspiciousness had disappeared to a large extent. There was active movement on the part of the patients throughout much of the day, and ward game material was in frequent use. Patients began to use and read the patients' bulletin board, where they would search for group assignments or put up cartoons for their own amusement. Housekeeping tasks were not accomplished with the same "spit and polish" perfection, but an adequate standard of cleanliness was maintained. Monthly parties were attended by the patients with great enthusiasm. These affairs had been received previously by either apathetic or hebephrenic-like behavior on the part of the patients. They now planned for the parties in advance by making and serving their own food and organizing their own recreation. The party served as the high point of the month, and the ward spirit that was generated by these affairs was remarkable.

It is quite clear that the content of the psychotic patient was not in any way directly affected by the program. However, there was an improvement in the general socializing level despite either psychotic content or affect. Though the level of acceptable behavior for each patient was raised over that previously present on the ward, this change did not adversely affect transfers into the ward, since it was found that patients coming to "A" ward from the disturbed admission ward were able to function at the level of organization the program demanded.

Conclusions

It can be seen that the role of the psychiatrist in this state hospital changed through an awareness of the over-all social setting in which he worked. The way in which this approach was used on a state hospital ward has been described. The physician carried out his administrative and therapeutic responsibilities, not only by ordering medications, daily routines, and special therapies for his patients, but by altering the social milieu. In laying the groundwork for a more therapeutic milieu, he cast aside the old relationship of the ward doctor to the nursing personnel, in which the doctor was an inaccessible, authoritarian being who wanted the ward to be quiet and neat. He set about to develop a new relationship with the personnel in which they were all members of a treatment team with the doctor as leader. He defined for the treatment team new objectives of personnel-patient relationship and taught them new methods by which to attain this goal. In this instance, he was able to go still further and formulate a program utilizing a type of group-therapy technique based on available facilities. In doing this, he functioned as a social scientist who investigated spontaneous group structures and ego functioning levels. He served as an enthusiastic salesman and trouble shooter who could not ignore the interpersonal relationships of the people with whom he worked or the way they influenced daily ward living.

Once the program was established the psychiatrist had created for himself an entirely new role. He was then the supervising therapist, administrator, and co-ordinator of a functioning treatment team. This team's attentions and interests were no longer displaced from the patients to shiny door knobs or the magic of a treatment ritual, but were intimately concerned with the welfare and well-being of every patient on the ward. Thus the psychia-

trist, through his contacts with the personnel and through the personnel's contacts with the patients, established a closely knit chain of interpersonal relationships which could be examined and supervised. When this was accomplished, the physician had succeeded in molding his assigned area into a co-ordinated social field in which maximal opportunity for ego-integration was provided.

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EMOTIONAL PROBLEMS OF THE MIDDLE-AGED MAN

BY OTTO BILLIG, M. D., AND ROBERT ADAMS, M. D.

In comparison with the amount of material written about the middle-aged woman, little attention is paid to this period of life in the male. Most published studies have been devoted to endocrinological data and symptomatology of the "male climacteric."

Heller and Myers[1] postulated the concept of a "male climacteric" as an entity comparable to the menopause in women. Twenty-three of their cases had elevation of gonadotropic hormone excretion comparable to that in castrated males. These authors separated the male climacteric patients from psychoneurotic men with similar symptoms, by endocrine studies and by the response of these patients to replacement hormone therapy. They believed the syndrome of the male climacteric to be relatively rare.

Landrum[2] pointed out the difficulties of quantitative determination of circulating androgens needed to prove decreased gonadal function. He could find only a "symptomatic but otherwise occult testicular deficiency." He agreed that the "male climacteric" syndrome was infrequent.

The symptomatology is adequately described by Werner[3, 4] in an article reporting 273 cases. All complained of "nervousness." The more common complaints were depression, irritability, decreased memory and concentration, crying, sleep disturbances, worry, loss of interest and self-confidence, headache. Circulatory complaints included sweating, vertigo, numbness and tingling, tachycardia and palpitation. "Hot flashes" were a complaint in Werner's patients, though other authors did not find this. Other general symptoms included fatiguability and potency disturbances. Werner attributed the syndrome of the male climacteric to a decreased gonadal function resulting in a disturbance of the pituitary-gonad equilibrium. Since all of the symptoms described are seen in psychoneuroses, they are not specific for decreased testicular function. Bauer,[5] in a criticism of the article by Heller and Myers, held that the term, male climacteric, should be used to designate the cessation of gonadal function at a definite period of life, with all symptoms a consequence of this alteration of the endocrine function. Lansing[6] expressed similar views. Landrum held that the symptoms of the male climacteric were psychogenic and that the term should not be used.

The term, male climacteric, implies a physiological, inevitable major change in the life of every man, comparable to that occurring in women. There is no evidence at this time to support such a concept.

The term is being used, then, to cover a psychiatric syndrome occurring in the middle-aged man, rather than a relatively rare condition of testicular insufficiency. Prados and Ruddick[7] reported 30 such cases. They postulated that glandular disturbances with attendant waning sexual powers threaten the man with loss of his love object, mobilizing and reactivating previous conflicts and anxieties. He is thus forced to regress to pregenital levels with symptoms reflecting passivity and dependence.

It may prove worth while to investigate the emotional meaning of middle age in our society. Dunn noted in a discussion of Werner's article that the "male climacteric" was important because it occurred usually in men with great responsibilities. The patients in Prados and Ruddick's series frequently gave a history of ambition and striving for achievement and success. A recent study described the dependency needs and depressive features of middle-aged miners as contrasted with anxiety neuroses in the younger generation. The cultural and economic factors were considered important contributing areas.

On becoming of middle age, the man of Western culture has reached another important period in his life. We have only to visualize his position within his own family and within his cultural group. Up to that time he has gathered new experiences which emphasized his need to prove himself and to gain recognition; to be successful, he had to struggle and to compete. He had to defend himself against competition—otherwise, he would have failed. Success in his job, social position and family were based on acceptance by his group—at first at home, then in school, and later in his job. As Margaret Mead points out, competition plays a basic dynamic role in the American family. The mother permits the child a great deal of freedom and shows considerable love, but it is conditioned on success—in play with other children, with rivals at school and in sports. Such conditional love is withdrawn—to a greater or lesser degree—when the child is unsuccessful. By this factor, anxieties and insecurities are produced: Lack of success may mean loss of love. The importance of leadership is emphasized from early childhood on. Knowledge and ability are not recognized on their

own merit, but primarily for what they mean in relation to others. The parent, the teacher, and later the foreman are not satisfied with achievement, but with how the individual rates in his class-standing or in his production. The child learns to struggle for position and power. This conditional love makes him eager to outdo and displace his rival. He may not be able to accomplish this at the moment, but hopes to achieve it when he has gathered more strength and experience. The need for displacing the successful rival has found innumerable expressions in all Western literature. The dynamic struggle between the rivals has been primarily observed from the viewpoint of the one struggling for success or leadership—in the Oedipus myth from Oedipus' viewpoint. It seems that the older man's fear of his younger rival has not been sufficiently emphasized as a dynamic force. But in Sophocles' play it receives support in Jocasta's words: ". . . that Laius should die —the dread thing which he feared—by his child's hand." And Laius was killed with "the silver just lightly strewn among his hair"—apparently at middle age. The prophecy of the oracle symbolizes the inherent struggle between generations.*

The father's unconscious hostility toward his unborn child is found in the custom of the couvade. Among some primitive tribes the "expectant father" must refrain from any activity. His actions are believed to bring death, injury or malformation to the child,[8] the symbolism of activity betraying his hostile intents. ". . . the retaliative nature of the taboo [demands], that the father should suffer the same torture which he wished to inflict on his child. . . ." In some primitive societies the father sacrifices with gifts to the mother's brothers[9]; in our society he passes out cigars when a son is born to him. Occasionally, the unacceptable birth intensifies his anxiety to the point of a frank psychosis.

Case 1

A 25-year-old high school teacher was admitted to the hospital with the complaint of, "I think I am going crazy." His symptoms developed rather acutely one month prior to admission with a typical anxiety attack during his wife's fifth month of pregnancy. Afterward he became fearful of having a brain tumor. Physical examinations by several doctors and specialists did not satisfy him. He became increasingly preoccupied with his symptoms, considering himself hopeless. He lost interest in his sur-

*Parallel themes can be found from the myths of many people to modern plays such as *The Death of a Salesman.*

roundings and appeared in a "daze." He complained of feeling unreal and showed moderate ideas of reference.

The patient is the youngest of six children. The mother was 10 years older than the father and was 49 years old when the patient was born. The father had desired an older wife, since "men die younger than their wives." Although neither parent had finished grammar school they were extremely ambitious for their children. All the patient's siblings finished college, receiving either masters' or Ph.D. degrees. Little affection was shown at home. The father worked long hours, never having any spare time for the children. When at home, the children had to be quiet in order not to disturb him. The father was strict and emotionally unresponsive. During his childhood, the patient showed enuresis, nightmares, sleep walking. He appeared destructive and was described as a "dare-devil."

The patient married at the age of 22, his wife being a year older. She is a very controlling individual. About 18 months before his admission to the hospital, the patient's wife had a spontaneous abortion. It was a planned pregnancy, and the patient appeared very grieved immediately after the abortion. But he once mentioned later that he was not sorry that they had lost the first pregnancy. The onset of the patient's emotional disturbance was laid in the fifth month of the wife's second pregnancy. The patient hinted that he didn't want this child either. When his wife threatened to abort during the third and fourth month, he expressed hope for an abortion. Soon afterward, he began to appear moody and withdrawn, and developed the symptoms described.

Apparently, the dissociative episode was precipitated by the wife's pregnancy and threatened abortion. The patient was closely attached to his own mother and showed marked antagonism against a severe and unresponsive father figure. He felt powerless in expressing his hostile feelings when he was a child—repressions resulted. The pregnancy of his wife, the abortion and his ill-concealed wish for a second abortion created marked conflicts. His hostile desires against the unborn child reactivated his own unresolved Oedipal feelings and his awareness of his original hostility toward his own father. The resultant guilt led him to the role of Laius when the oracle predicted his death "by his child's hand." He then defended himself by displacing his repressed hostility from his father to his yet unborn child. But he developed the anxiety of Laius that his child would "kill" him when it reached maturity—that is, with "the silver just lightly strewn among his hair," his own middle age.*

*Reik calls attention to certain South American tribes who consider "the child [. . . as] the father of the man." The grandfather is called the "*little* father." Their rituals seek protection from the fear that the grandfather will come to life in the grandchild. The Indian man fears that the hostility against his own father will be avenged by his child. A similar mechanism is pointed out by E. Jones in *The Phantasy on Reversal of Generations.*

Therefore, one can expect two vulnerable periods in the adult man who has not resolved his Oedipal conflict: (1) at the birth of a child, particularly of the first male child; (2) at middle age when he fears that his real (or symbolic) son has grown sufficiently powerful to displace him.

Case 2

A small-town merchant, aged 54, has shown depressive and, alternating, elated moods for the last five years. The illness started shortly after an automobile accident to his only son. It was necessary for the patient to sign some insurance papers. Soon afterward he developed delusions of having done something wrong and that he would be sent to jail. The symptoms were intensified, and he became severely depressed.

The patient had grown up in a very rigid and narrowly religious home. The father was described as a domineering, unreasonably strict man who punished the patient severely with slight provocation. A poor provider, the father spent many months away from home looking for jobs. There was considerable tension, and the patient witnessed frequent quarrels. The mother was affectionate and kind, and the patient considered himself the mother's favorite. She was particularly attentive to him during the father's long absences; she allowed him to sleep in bed with her while the father was away. The patient looked forward to the father's trips and often wished that he would not return.

The patient is the youngest of seven siblings; he had five brothers and a sister. The oldest brother's personality is described as very much like the father's, an austere, emotionally cold and rigid person. This is in direct contrast to the patient who is well liked in the community, has many friends, was always "jolly" and very much interested in the welfare of others. At the age of 25, the patient planned to open a store with a friend but was encouraged by the family to go in business with the oldest brother. The patient was controlled by the oldest brother, and all business policies were determined by this brother, who was extremely conservative, while the patient was full of new expansive ideas. The patient resented being restricted, but never felt able to assert himself. A few years ago he had tried to take his son into his business but the brother objected, believing that the patient wanted to push him, the brother, out. Following this the patient set his son up in business alone, actually as a competitor to himself, and to his financial loss. The patient did this despite never having been close to his son.

In the beginning of his marriage the patient did not welcome the wife's pregnancy, since a child would be a "financial burden" at the time "I started out in business." He was also openly jealous of his wife's attention to the son and resented their discussing matters. It was the patient's

impression that he was not welcome to participate in such discussions and felt "pushed out." He wanted the son to support him completely when he, himself, became depressed, just as his own father had demanded such support from his children. He resented the son's "spending money on his girlfriend, buying a car and having a good time."

The cultural environment increased the emotional conflicts of the patient. The small southern town where he lived fostered definitely outlined traditions of community life. The family belonged to a rigid and strict church in which the oldest brother was a deacon. The patient's concept of God was that God could see everything and would punish all evil done. God was a stern and unforgiving figure.

To summarize: A male patient develops a severe depression at the age of 49, following an accident to his son. The patient had had a poor relationship with his own father, with ill-concealed death wishes against the father. He was strongly attached to a solicitous mother. The oldest brother continued in the role of the punitive father, maintaining similar hostile feelings in the patient. The cultural environment intensified the conflicts, contributing to the existing feelings of guilt. The patient felt threatened by the relationship between his son and his wife, creating a reactivation of his own earlier Oedipal feelings. The son's accident precipitated the clinical symptoms.

The "male climacteric" depressions have been more frequently recognized in "successful" men. Such men have been able to prove themselves in competition. As pointed out previously, this competition is built on a "conditioned" love. The threat of the loss of love lends itself to introjection of the conflict and subsequent depression.[10]

In non-competitive (or better: low-competitive) social groups, love and approval are not conditioned on success. Existing unresolved Oedipal conflicts are expressed in conversion or anxiety reactions. About 150 patients (almost all males) of an industrial group were studied. They were admitted to Vanderbilt University Hospital with one or another form of persistent, handicapping illness. Over 75 per cent of these patients were between 35 and 55 years old; more than half of the middle-aged men had clear-cut emotional illnesses, primarily anxiety and conversion reactions, while an additional third had psychosomatic problems. Only about 15 per cent of all middle-aged patients proved to have definite organic diseases. The emotional reactions were precipitated by minor accidents or injuries in about 15 per cent while the reactions of an additional 10 per cent were preceded by some kind of physi-

cal difficulty. The patient group came from isolated mountain areas of a culturally-restricted environment of rigid standards. Its members had little contact with outside groups.

The case histories were of striking similarity, almost stereotyped: The father was usually strict, austere; he "made the children walk the chalk line." The mother often suffered from long-lasting neurotic complaints. Little outward affection was shown in the home; the family was often pre-occupied with meeting the most immediate necessities of life. The country was barren and not sufficiently productive. There were usually several other children of the family; its members left the small country town rarely; they visited the larger cities only in cases of some emergency. Neuropathic traits of childhood such as enuresis, nail biting, nocturnal fears were frequent and were usually handled by shaming or other disciplinary measures. School attendance was poor, often considered as an unnecessary luxury interfering with supporting the family. The boys started to help the father, working on the farm or in the mines at an early age, not infrequently before being 10 years old. A boy, insecure in his relation to his strict father, was often afraid of him. The late 'teens were a difficult adjustment period characterized by various forms of rebellion. The early years of marriage were difficult; the young husband preferred "to run around with the boys," did heavy social drinking; the young wife nagged him to "settle down." Several children were born within a few years. In most cases, the young man became a steady worker giving up "the gang." He worked hard and long hours with little outside contacts. He belonged to a fundamentalist church. Approaching middle age he became increasingly concerned with his health. A minor illness, injury or accident might precipitate a several emotional reaction, either an anxiety or conversion reaction. Treatment usually proved difficult because of the educational and cultural limitations.

It seems also that in these cases the patient was unable to resolve his Oedipal feelings with a strict threatening father. He had to repress his hostile feelings against him at an early age, but rebelled against authoritarian figures during his adolescence and early adulthood. He had difficulties in assuming the marital role, both as husband and father, manifesting anxiety or conversion symptoms at middle age.

The man who has emotional disturbances during midlife is likely to be the man who has only partially resolved his own Oedipal conflicts. These conflicts do not always result in definite clinical syndromes but may become manifest in certain personality patterns leading gradually to a change in cultural attitudes. The unconscious hostility of the elder toward the younger is symbolized in the primitive customs of initiation ceremonies in which the young member of the tribe is "tested" by the witch doctor, the symbol of tribal authority. The youth has to undergo severe tests that are only manifestations of his elders' marked aggression toward him. The novice may die a symbolic death; when he is reborn as a full (adult) member he may not be permitted to mention the names of his family. This protective amnesia prevents him from contacts with his father and mother. The hazing performed by medieval labor guilds or modern fraternities probably could be traced back to similar mechanisms.

The unacceptance of the son who is a rival often results in a contempt for his activities. "The American father, brought up in the tradition of the pioneers, hardened in the period of rugged individualism, absorbed in the creation of material wealth, often looks down contemptuously upon his son's interest in history, literature, or even theoretical physics. He considers such inclinations a sign of decline, particularly if they do not produce adequate material rewards."[11] In other cases such unacceptance of the rival son may, however, result in the father's discontent with the son's lack of interest in intellectual achievements, provided the father himself has attained intellectual goals. The specific attitudes may vary, but the basic mechanism appears to be the intolerance of the father for the son, possibly rationalized in a desire of the father to "harden his son for life . . ." or, "I didn't have it easy . . . life is not a bed of roses."

The underlying anxiety can be also transformed into protective and solicitous attitudes. The father will encourage a role of dependency by "I want my children to have it easier." But he becomes disturbed by any sign of emancipation.

Case 3

A successful business man, aged 55, is the son of Russian, Jewish emigrants. The parents had come to a small southern town and were very conscious of their minority role. They worked hard and had little time for

the children. The father was a strict disciplinarian; considerable tension existed between the parents. The patient entered the father's business at an early age. He married at the age of 20; he had three sons. He made great demands on them, insisting on high grades in school. After they had finished school, he made his sons junior partners in his business. When one of them showed other interests, the patient called him ungrateful, reminding him of the great sacrifices he, the father, had made in raising him and his brothers. When the two older sons planned to marry, the patient objected to their fiancees, finding fault with them or considering the sons to be too young for marriage. When he realized their determination, he became rather solicitous, presenting them with real estate next to his own home. He helped them finance the building of their homes. After their marriages he continued to demand their frequent visits to his home next door. Finally, the oldest son broke with the patient, leaving the business and moving to the West Coast. The father became increasingly depressed, and this depression culminated in a suicidal attempt.

In summary, the patient suffered severe rejection from both parents during his early childhood and felt particularly threatened by his father. He was unable to handle his relationship to his own sons, controlling them by keeping them in roles of dependency. Marked anxiety and feelings of depression were elicited at middle age when his oldest son established an independent role.

The emotional conflicts do not always reach proportions of clinical magnitude. The anxieties or depressions appear as the late manifestations of unresolved Oedipal conflicts. If such conflicts are resolved, however, the middle-aged man can accept the younger man. And only then will he be able to live and work with him as an equal without needing defenses against potential threats.

Treatment has proved to be difficult in all the writers' cases. The cultural limitations in some cases presented the obstacles to be expected to effective psychotherapy. The treatment of comparatively simple anxiety reactions proved to be rather problematic in middle age, even if cultural limitations were not present. To give the patient insight into only the simplest dynamic mechanisms, intensive psychotherapy had to be carried out over one to four years.

The depressed patients showed considerable resistance to therapy. Electric shock treatments have been considered successful, in other cases, in the various depressive reactions. But in these patients, courses of 12 to 15 ECT's produced only temporary results; the remissions lasted not more than a few weeks. Further ECT did not produce additional benefits.

Case 2 had two courses of 12 ECT's; the second course was given six months after the first. The patient appeared temporarily improved after each course, but he continued with alternating moods of elation and depression without any days of actual comfort. Psychotherapy was started. The treatment goal had to be set in accordance with the cultural background (described in the foregoing). It was aimed to give him an understanding of the interpersonal relations to his father and mother, the continuing authoritative father role assumed by the oldest brother and the patient's relation to his own son. Treatment progressed considerably slower than in other patients of similar intellectual ability and cultural background. The interviews extended over a period of four years averaging two interviews weekly. Gradually the mood changes became less frequent and intense until, finally, the patient reached emotional stability.

Electric convulsive therapy produced a marked personality disorganization in several cases. Memory defects were more marked than usual; the affect became somewhat blunted. Increasing excitement was noticeable. Finally, the patients became disoriented, confused, and at times untidy. Some of them showed auditory hallucinations and had persecutory ideas. When electric shock therapy was discontinued, these symptoms disappeared spontaneously within two to four weeks.*

Summary

The emotional problems of the middle-aged man result either in anxiety or in depressive reactions. His own unresolved Oedipal conflicts make him vulnerable to his role as father. The birth of a child, particularly of the first child, may reactivate his conflicts, resulting in overt anxiety. When the son reaches adolescence the underlying conflicts may again mobilize his anxiety or produce a depressive reaction. The rivalry with his real or symbolic son (younger co-worker, etc.) is of basic dynamic significance. Certain cultural attitudes may reinforce the existing conflicts. Treatment aspects have been discussed.

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*It may be of interest to note that the authors have never observed similar reactions in women patients.

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AN INVESTIGATION OF CERTAIN PSYCHODIAGNOSTIC INDICATIONS OF SUICIDAL TENDENCIES AND DEPRESSION IN MENTAL HOSPITAL PATIENTS*

BY DANIEL C. BROIDA, PH.D.

Introduction

It was the purpose of this investigation to evaluate certain hypotheses which have been advanced in the literature on the Rorschach technique and the Thematic Apperception Test as they relate to the diagnosis of suicidal trend. More specifically, an attempt was made in this study to evaluate Lindner's suggestion[1] that Card IV of the Rorschach test may be viewed as the "suicide card" and Rapaport's contention[2] that Card 3 BM of the Thematic Apperception Test elicits suicidal preoccupation and depressive trends. In addition to the foregoing, an attempt was made to explore further symptomatic depression, as elicited by the depressive scale of the Minnesota Multiphasic Personality Inventory, as a diagnostic component of suicidal tendencies.

Use of the Rorschach technique in dealing with the problem of suicide has been investigated to a greater extent than the TAT. Three rather major studies on the Rorschach have been made which were specifically oriented to the suicide problem. These studies were conducted by Hertz[3, 4] and Fisher.[5] Beck[6] presents two individual case studies, using the Rorschach, involving suicide. Two other studies, one by Rabin[7] and the other by Lindner, have dealt with suicide only secondarily. Hertz' studies, utilizing a configurational analysis, were rather large in scope and no attempt will be made here to duplicate her work or test any of her hypotheses. However, it may be noted that Fisher's results did not substantiate Hertz' proposed "suicide configuration" type of analysis. In an article on content analysis in Rorschach work, Lindner suggests that Card IV may be viewed as the "suicide card": ". . . responses containing such statements as a 'decaying tooth', 'rotted tree

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trunk', 'a pall of black smoke', 'something rotten', 'a burned and charred piece of wood', are keys to severe depressive states with suicidal overtones and self-annihilative thought content." Regarding this hypothesis Hertz states: "Lindner's hypothesis concerning Card IV . . . must be viewed with extreme caution until systematic studies with suicidal, non-suicidal clinical groups and normal groups are made." Content such as proposed by Lindner did not significantly differentiate Fisher's suicidal and non-suicidal schizophrenic groups.

No systematic study of suicide employing the TAT has appeared in the literature. Tomkins[8] reports three TAT themes involving suicide in particular individuals, but does not offer any generalized hypotheses or relate them to specific cards. Rapaport[2] states that, "Card M-13 (3 BM of the current edition) usually elicits preoccupation with and causes of depression and suicide." He does not offer any data regarding the validity of the hypothesis or frequency of occurrence.

Hathaway and McKinley[9] in their standardization of the depressive scale of the MMPI, used, among other subjects, 50 patients who were in the depressed phase of a manic-depressive psychosis. They do not mention whether suicidal patients were included in any of the groups and no mention is made of the scale's usefulness regarding the depression factor in suicide. In a preliminary study of the MMPI with 50 suicidal patients and no controls, Simon and Hales[10] found a consistent rise in the D and Pt scales. They are of the opinion that a useful "suicide key" can be developed from the MMPI.

The present investigation[11] was undertaken to shed some light on the validity of three specific test hypotheses referred to in the foregoing regarding the diagnosis of suicide: (1) Suicidal individuals will produce more responses containing the content suggested by Lindner[1] to Rorschach Card IV than individuals who are not suicidal; (2) Suicidal individuals will produce more suicidal themes to Card 3 BM of the TAT than individuals who are not suicidal; and (3) Suicidal individuals will obtain a significantly higher score on the MMPI depressive scale than individuals who are not suicidal.

In addition to the aforementioned basic hypotheses, several corollary problems were examined. These will be specifically referred to in the discussion which follows.

Procedure

The experimental group selected for this study consisted of 20 patients diagnosed as suicidal who were on a neuropsychiatric "suicide ward" in a Veterans Administration hospital. The subjects were selected by the ward psychiatrist who was asked to select from all the patients on the ward those whom he believed to be most suicidal. Specifically, he was asked to select only those who had made definite attempts at suicide and/or those who had expressed suicidal contemplation excessively. The author carefully went through the case histories of the 20 individuals selected. Of the 20, it was found that 10 had made definite attempts at committing suicide. Those who merely had suicidal ideation were all characterized as being "very depressed" and as having expressed definite desires to commit suicide; and, it was felt, they would do so if left alone. All of those who had made active attempts at suicide had also expressed suicidal ideas.

The control subjects were selected as follows: The author went through the hospital files and noted those patients with diagnoses which were similar to the diagnoses of the individuals constituting the experimental group. From these cases, he selected 20 which most closely matched the experimental group in terms of age, educational level, occupation, and marital status. All the control subjects selected were on wards other than the suicidal one. The case histories of these subjects were analyzed as to content concerning suicidal reports. There was a lack of such reports in all the control cases, as regards both suicidal attempts and ideation.

The matching of the two groups as regards diagnosis was exact. Of the 40 subjects, 32 were exhibiting psychotic reactions. The predominant nosological classification was schizophrenic reaction, catatonic type. Two subjects were diagnosed manic-depressive reaction, depressive type; four were psychoneurotic; and two were epileptic. Ages, educational levels, and marital status of the two groups are shown in Table 1.

Table 1. Age, Education and Marital Status of Experimental and Control Groups

		Age		Education		
Group	No.	Range	Mean	Range	Mean	No. married
Suicide	20	20-44	28.6	4-15	10.70	4
Non-suicide	20	22-42	28.3	8-14	10.85	4

It will be noted from Table 1 that the matching was very close. The suicide group tended to have a somewhat wider, though probably insignificantly wider, range as regards both age and educational level. Utilizing the United States Census Bureau breakdown of occupational levels for all subjects, close matching was again obtained. The subjects, as a whole, tended to fall toward the laborer end of the continuum. All the subjects were white and came from small and large towns in the eastern states; none came from any metropolis.

To all 40 subjects, the author individually administered the following in the order presented: (1) Cards I, II, III, and IV of the Rorschach test; (2) Cards 1 and 3 BM of the Murray TAT; and (3) The depressive scale of the MMPI. With the non-suicidal subjects at the close of the testing period, the investigator asked the following questions as a further check on the absence of suicidal inclinations: (1) "Have you ever attempted to commit suicide?" and (2) "Have you ever thought of committing suicide?" In all instances the answer was negative to both questions. With the exception of these questions, the procedure in test administration was identical for both groups.

Since interest in the Rorschach aspect of this inquiry was primarily directed toward the content of the responses to Card IV, the entire test was not administered. However, Cards I, II, and III were administered solely for the influence they might exert before presentation of Card IV. Recent research[12] has corroborated Rorschach's earlier contention that the order of presentation of the blots is an important variable, and departure from it will influence responses. Inquiry was employed for all four cards on the conclusion of the free association period. Following this, a method of testing the limits was employed using the Lindner responses in the following manner: "Now I'm going to name some things. See if you can point them out to me. I'd like to know how you feel about them; that is whether or not they look reasonable (okay) to you." The Lindner responses were then presented in the following order: (1) a decaying tooth, (2) rotted tree trunk, (3) pall (cloud) of black smoke, (4) something rotten, and (5) a burned and charred piece of wood. If the subject denied seeing any of the responses, the examiner pointed them out in a more elaborate manner (usually as a W response with shading) and then asked the patient if he saw them.

The TAT was introduced by the experimenter using the standard directions (Form B) given by Murray,[13] which is designated as the form to use with psychotics. Card I was then shown to the patient and his response was recorded verbatim. Card I was used to acquaint the subject with the procedure, and, with this end in mind, he was asked to conform as closely as possible to the original instructions. The intermittent inquiry followed by Stein[14] was resorted to. Intermittent inquiry was resorted to with Card 3 BM in the form of, "What led up to it"? "How does he (she) feel"? "How will it end"? Somewhat more freedom to produce the story here than in Card I was permitted. Responses to Card 3 BM were carefully recorded. The time lapse between presentation of the card and response to it was recorded for all subjects.

Only the Depressive Scale of the MMPI was administered.* The question may arise in the reader's mind as to the validity of such a procedure. It seems justified since the scale was standardized separately in such a form. In addition, the K factor does not influence the D scale scores or norms.[15]

Method of Analysis

All responses to Card IV of the Rorschach were scored by the author. When the scoring was doubtful or equivocal, he enlisted the aid of a psychologist with wide experience in Rorschach testing, and the final scoring was arrived at mutually. The frequency of spontaneous responses that were either identical or similar to those proposed by Lindner was tabulated. The testing-the-limits data were broken down into the following three categories: (1) seen spontaneously when suggested, (2) the percept shown and accepted by the subject, and (3) the percept shown and rejected by the subject.

In addition to the foregoing, in order to glean as much as possible from the data in terms of differentials other than those proposed by Lindner, all the responses given to Card IV by the two groups were tabulated. Fisher's t ratio was employed to test the significance of the difference between the mean T/1R and mean number of responses given to the card by the suicidal and non-suicidal groups. A percentage comparison of the two groups was made in terms of all scoring factors.

*The form used consisted of three mimeographed pages containing the 60 items which make up the scale.

The 40 stories given to TAT Card 3 BM were presented to five judges, who were psychologists, for independent analysis. They were asked to indicate the essential or predominant theme in terms of one of the following:*

1. Suicide:
   Attempted, completed, or preoccupation with;
2. Depression:
   Unhappy, crying, grief, generalized frustration;
3. Pressure from parents;
   Parent figures are prohibitive, compelling, censuring, quarreling with child;
4. Fatigue:
   Tired, resting, sleeping;
5. Aggression:
   Toward others with or without ensuing guilt feelings or regret;
6. Too scanty for theme identification.

In addition to theme identification, the judges were asked to designate the type of theme-ending in terms of one of the four following categories: (1) happy, (2) neutral, (3) unhappy, and (4) undecided or ambivalent. This latter analysis was done because endings of themes seem to have some pertinence in interpretation.[18] Because there has been considerable comment and some confusion in the literature regarding the significance of misperceptions of the sex of the figures on TAT cards,[2, 14, 16, 17, 18] the investigator tabulated the frequency and type of figure perceived by the individuals composing the two groups.

The raw scores each of the subjects obtained on the MMPI D scale were converted into T scores in accordance with the Manual. The *t* ratio was utilized to determine whether or not there was a significant difference between the means obtained by the two groups.

Results

Tabulation of the free association responses to Rorschach Card IV reveals that responses identical or comparable to those suggested by Lindner occurred three times, or in 15 per cent of the

*The theme breakdown was taken in part from a study by Eron (Ref. 16). Several added points were selected by the author to include what seemed to be all other possibilities.

suicidal group. There was a complete absence of any such response among the non-suicidal group. The following are the verbatim responses given by the three suicidal patients:

1. "A badly cured hide; it's disintegrated and decomposed."
2. "Piece of petrified or decayed wood or metal."
3. "Moth eaten bear rug; it looks somewhat rotten."

All of these responses were scored W and the determinants were either FY or YF. Testing the limits, using the five Lindner responses, showed no differences between the two groups. Something over half the members of each of the groups spontaneously accepted all of the responses when they were suggested by the investigator.

The *t* ratio which was computed to determine whether or not there was a significant difference between the mean number of responses given to Card IV by the two groups was significant at the 6 per cent level of confidence. The suicidal group obtained a higher mean (2.55) than the non-suicidal group (1.60). However, the variance ratio was statistically significant, raising the question of the validity of the *t* ratio in this instance. It is of importance that the suicidal group, in terms of number of responses, showed a wider range and greater variability than the non-suicidal group. Although the suicidal group gave, on the average, a shorter T/1R to Card IV than the non-suicidal group, the difference was not significant at a statistically acceptable level. The percentage comparison based on the number of responses given to Card IV between the two groups on all scoring categories showed certain trends; however, a significant difference (as determined by the CR of percentages) was found in the case of only one category, i. e., A%. The non-suicidal group gave the greater number of animal responses. Since the comparison was made on 29 different factors, a single significant factor is less than would be expected on the basis of chance expectancy. However, as indicated previously, certain consistent trends were apparent. The suicidal group showed a generally more pathologic picture than the non-suicidal group in terms of such factors as higher Dd, DW, YF, Y, Hdx, An, Sex and lower P, M, F+ and H.

For a theme or ending on TAT Card 3 BM to be categorized, agreement of the five judges on at least three of their designations (60 per cent agreement) had to occur. If this level of agreement did not occur for both the theme and the ending, then only

the one so substantiated was used. Such agreement was reached or exceeded in the case of all themes produced by the suicidal group and on 19 of the 20 themes produced by the non-suicidal group. In terms of endings, the agreement was not so good, although agreement above chance expectancy was obtained. Neither individual Chi-squares nor a total Chi-square used to evaluate the difference in frequency of type of themes produced by the two groups were statistically significant. Both groups produced an approximately equal number of themes in the various categories. Two members of the suicidal group produced themes designated "suicide" as contrasted with one such theme from a member of the non-suicidal group. Something over half the members of each of the groups produced themes which were categorized as "depression."

In regard to theme endings individual Chi-squares revealed that one ending, "happy," approached statistical significance ($P=<.10$), the suicidal group having produced the greater number of themes with happy endings. A total Chi-square was significant at better than the 5 per cent level of confidence, indicating a significant difference between the two groups in terms of theme endings. The analysis of the sex of the figure in TAT Card 3 BM as perceived by the suicidal and non-suicidal groups revealed a trend ($P=<.10$) on the part of the suicidal group to be more confused (to fluctuate from male to female within a theme) and to see the figure as a male less frequently than the non-suicidal group. Length of theme (i. e., mean number of words used) and mean reaction time to Card 3 BM did not significantly differentiate the two groups.

The suicidal group obtained a mean T score on the MMPI D scale of 74.63 as contrasted with a mean T score of 62.85 for the non-suicidal group. The t ratio (2.076) yielded a probability value of about .02.*

Discussion

Though the evidence is meager, it tends tentatively and with certain qualifications to verify the hypothesis that Rorschach Card IV may be viewed as a "suicide card." Although responses such as those suggested by Lindner occurred in only 15 per cent

*The P value was obtained using t as a one-tailed test of significance since the direction of the difference was predicted.

of the experimental group, the complete absence of any such responses in the non-suicidal group would tend to support the hypothesis. The present findings are somewhat more positive than those obtained by Fisher,[5] who found that some individual non-suicidal subjects give many more "self-destructive" responses than the suicidal. However, in agreement with his findings, statistical significance is also lacking here in the present inquiry. Perhaps it would be more accurate to qualify the hypothesis in the following terms: Responses such as those suggested by Lindner[1] will tend to appear on occasion in the records of suicidal individuals, but the absence of such responses would certainly not negate the possibility of suicidal inclinations. Further, the presence of such a response in a record should not be taken as conclusive evidence of suicidal tendencies unless there are supporting data.

The suicidal group gave a consistently more pathologic picture in terms of other responses to the card, although statistical significance was lacking. Whether this was a function of the intrinsic nature of this particular "suicide stimulus" or the possibility that the suicidal group was more deteriorated than the non-suicidal group and would have displayed this greater degree of psychologic impairment on any Rorschach card, was not examined. However, from other test data and case history material, the latter possibility seems to be more likely in spite of the fact that the two groups were perfectly matched in regard to psychiatric diagnosis.

The hypothesis that TAT Card 3 BM elicits suicidal preoccupation and contemplation was not borne out. The hypothesis that the card does elicit depression was supported to some extent and will be discussed more fully. This investigator is forced to conclude from the present results that suicidal themes on Card 3 BM are probably more often a function of the stimulus value of the Card *per se*, rather than a function of individual dynamics or of the psychological make-up of the individual. This conclusion is in accord with Eron[16] who found only 13 categories out of 100 on the TAT that differentiated between normal college students and schizophrenic patients. It seems that we are often dealing with cultural stereotypes and clichés, resultant from the "loaded" nature of the TAT stimuli, which must be ruled out before individual dynamics become apparent. The need for adequate normative data for such

projective material is strongly suggested by the present findings and the other studies referred to in the foregoing.

In contrast with the clinical picture presented and the case history material, it is to be noted that the suicidal group tended to give more "happy" (or "neutral") endings, as compared to a greater incidence of "unhappy" endings in the non-suicidal group. This finding, which is rather in contradiction to what might be expected, should make the researcher and clinician duly wary of presumed relationships between endings to TAT stories and actual life experiences.

Although Stein maintains that reaction time to TAT cards is of importance and should be recorded, the lack of norms notwithstanding, the present investigation offers no support for such a contention. The expectation that suicidal patients would be "shocked" by the card was not evident here, at least insofar as delayed reaction time is a measure of "shock." However, disturbances on the card were manifest in the suicidal patients' more frequent distortion of the sex of the figure than the non-suicidal patients.

The fact that the MMPI D scale significantly differentiated the two groups as was hypothesized, would seem to indicate that more fruitful research might be done with the scale in the hope that a "suicide key," as suggested by Simon and Hales,[10] might eventually be developed. Further, the present findings support the original contention of the authors of the MMPI *viz.*, that the scale seems to be a valid measure of depression.*

There was no clear-cut consistency among the three tests as might have been expected. None of the individuals who gave the Lindner response produced suicidal themes on TAT Card 3 BM. They did, however, consistently show higher MMPI depressive scores than the mean for their group. Psychiatric diagnoses varied. All were high school graduates.

*The MMPI depressive scores were tabulated for those individuals in both groups who gave depressive TAT themes. The mean MMPI score for the suicide group who received depressive designations for their TAT production was 77.90 as contrasted with the mean score for the entire group of 74.63. The mean MMPI depressive score for the non-suicidal group was 62.85 while the mean score for only those who gave depressive TAT themes was 64.10. This would tend to validate the judgments and verify part of the original contention that TAT Card 3 BM elicits themes involving depression.

Summary

This study was undertaken to evaluate certain cues as regards the diagnosis of suicide by use of content analysis of Rorschach Card IV and TAT Card 3 BM. In addition, an attempt was made to examine the depressive factor in suicide as elicited by the MMPI D scale.

The subjects used in this investigation consisted of 20 suicidal mental hospital patients and 20 non-suicidal patients as controls.

Administration of the tests was individual. The method of analysis consisted of both quantitative and qualitative approaches.

The results and conclusions of this study are:

1. Responses to Rorschach Card IV containing content proposed by Lindner as being indicative of "suicidal overtones" occurred three times among three different individuals in the experimental suicidal group. There was an absence of such responses in the records of 20 non-suicidal controls. It was concluded that the evidence was meager but tended tentatively and with qualifications to support the contention that Card IV may be viewed as a "suicide card." It was proposed that caution be used in applying such content analysis in practice, as the incidence and validity of such responses are still largely unknown. Corroborative data would seem essential before a diagnosis of suicidal may be made. The suicidal group, on the whole, gave other responses to the card which appeared to be consistently more pathological than the non-suicidal controls, but statistical significance was lacking.

2. Analysis of themes to TAT Card 3 BM showed that the card does not differentiate between the two groups as regards either the production of suicidal, depressive, or other types of themes. In addition, the card does not differentiate as regards time before responding, or length of protocol, although the suicide group exhibited greater variability on the latter two aspects. Chi-square test results on theme endings, taken as a whole, significantly differentiated the two groups. Possibly contrary to popular belief, the suicidal group produced a greater number of themes with "happy" endings than the non-suicidal group. Misrecognition of the sex of the figure occurred with greater frequency (10 per cent level of confidence) among the suicidal than the non-suicidal subjects. It was suggested that the production of suicidal themes on this card was probably more an artifact of the stimulus value of the card,

per se, or a cultural stereotype than a reflection of individual dynamics. Card 3 BM does lend itself to depressive themes, the production of which seems to correlate positively with MMPI D scale scores.

3. The MMPI D scale significantly differentiated the two groups in the direction postulated.

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PSYCHOTHERAPY IN A MENTAL HYGIENE CLINIC

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I

In recent years there has been a progressive increase in the number of mental hygiene clinics throughout the country. These clinics feature psychotherapy as the main treatment technique and are in large part sponsored by hospitals, state mental hygiene systems, the Veterans Administration, and community funds—with a sprinkling of other supporting agencies. They vary greatly in size and adequacy of personnel, depending on geographical location, financial support, and availability of qualified people.

Generally speaking, everybody is more or less in agreement that this development is necessary or worth while. It is accepted by the public as well as by forward-looking officials and institutions. Growth will no doubt continue.

However, it seems justified to ask questions about certain aspects of clinic activity. For example, is psychotherapy in an outpatient clinic in any way comparable to private psychiatric care in value for the patient? Does clinic psychotherapy reduce the need for hospitalization of potentially psychotic patients? What criteria should be used in selecting personnel for a mental hygiene clinic? Is a good psychotherapist in private practice necessarily as competent or as useful in a clinic setting? What should be the role of ancillary personnel such as psychologists and social workers in the psychotherapeutic situation? Many other questions along similar lines may well be asked.

Some of these questions may appear superfluous to individuals with decided opinions about such matters as psychiatry, clinic practice and psychotherapy. Yet there is need for objectivity and study in the field of mental hygiene clinic functioning, and many questions relating to this activity remain only partially resolved at this time. After all, psychiatry itself is still comparatively young and in process of evolution. No particular school of thought or sector of the psychiatric profession should arrogate to itself the feeling that it knows "all the answers." Mental hygiene clinics, stemming from psychiatry as they do, are likewise in an early state of development and in need of review and occasional modifications, in line with improved understanding of what they are doing and with evolution in psychiatric thinking.

An excellent study published in 1949 by the New York City Committee on Mental Hygiene of the State Charities Aid Association,[1] consisting of a review of four representative psychiatric clinics in New York City, has contributed revealing data, some of which are worth highlighting.

Though all four clinics were staffed by "able therapists," only 25 per cent of the patients treated received effective therapy. The study suggested that in the clinic situation, factors other than training and experience in psychiatry contribute significantly to the outcome of therapy. One important factor stressed was good motivation for treatment on the part of the patient, as well as recognition by the patient that his problem was primarily emotional. Another factor enhancing effectiveness of subsequent treatment was contact with a psychiatric social worker at the beginning. When medical students were used to carry patients in therapy, there was a higher rate of effectiveness in treatment by the students than among the trained and experienced psychiatrists! This may perhaps be explained as due to the interest, enthusiasm, and responsiveness of the student as well as to the possible selection of patients.

II

With the foregoing as an introduction, it is proposed here to present some highlights and data based on six years of intimate association with the Brooklyn Regional Office Mental Hygiene Clinic of the United States Veterans Administration. In a previous communication,[2] the effectiveness of so-called "supportive" therapy for chronic patients was emphasized, and it was pointed out that almost all patients with psychiatric disorders can be helped, provided there are available facilities. This concept has been generally applied, and to such an extent that all patients applying for treatment, and entitled to it, are accepted unless they are so sick or disturbed as to require hospitalization.

Since this is a Veterans Administration clinic, treating only adults, with so-called service-connected or service-incurred psychiatric conditions, certain features peculiar to this clinic may not apply in entirety to other types of psychiatric outpatient organizations. For example, this clinic deals essentially with adult males. A large proportion of the patients are psychotics or borderline cases. Therapy is free. Many veterans are poorly motivated for

treatment and often come to the clinic only because of concern over pension problems. Broken or cancelled appointments are at a high level in many cases, making it difficult to establish rapport. One may imagine the difficulties a psychotherapist often faces in attempting therapy with a veteran who is being "rewarded" financially, by means of a pension, for the condition which is the reason for therapy! If the patient does improve under therapy, he may have his pension reduced at some later date! For such reasons it is the writer's belief that psychotherapy in a Veterans Administration clinic presents problems not faced by therapists in other types of mental hygiene clinics.

It is customary to divide psychotherapy into two categories; so-called "uncovering" or insight techniques, and "supportive" techniques. The former is generally regarded as the more or less exclusive domain of the psychoanalyst or psychoanalytically-oriented therapist. One assumes that the goal of this technique is to increase the ego's capacity to cope with conflicts having their origin essentially in childhood, and aggravated by current life situations. For this technique to be effective, a transference must be attained —with the patient regressing for a time to the dependency of childhood in relation to the therapist. This requires time and great frequency of interviews, in addition to suitable case material. In general, this approach, constituting as it does, formal psychoanalysis in the more rigid sense, is not feasible in the Brooklyn Veterans Administration clinic.

The reasons are clear. The number of therapists entirely qualified for this "uncovering" procedure is limited; the pressure of a heavy case load, which must be absorbed, is great; and patients suitable for analysis are few. Suitability for analysis is judged by the writer to depend on such factors as the nature of the psychiatric condition, real motivation for help, ability to conform to a rigid treatment regime, and a reasonably good level of intelligence.

However, a sizable group of therapists have used and continue to use what may be described as analytically-oriented psychotherapy, though their therapy may, in effect, be essentially supportive. As a matter of fact, psychotherapy in this clinic can be categorized as basically "supportive," whether performed by the analytically-oriented therapist or by what will be described here as the "eclectic" psychotherapist. By supportive therapy, it is meant that the patient's emotional distress is reduced by giving him opportuni-

ties for abreaction, while his dependency needs are maintained through his relationship to his therapist. When feasible, attempts are made to influence the patient's judgment by intellectual guidance. This can be effective when his basic distress has been sufficiently reduced. The therapist can even go further and, with the help of social service, influence the patient's environmental situation in given instances. If the therapist is sufficiently skilled, he can provide some support for the patient's neurotic defenses. The therapist does not have to be an analyst or even analytically-oriented to perform these functions.

Supportive treatment of this type will vary considerably in depth, depending not only on the type of patient under treatment but also on the ability of the therapist. Some degree of "uncovering" and of "insight" is bound to occur in many, if not most, patients. It is the writer's experience that such therapy is not only effective in episodic and mild psychiatric disorders but also in the more profound conditions. It is valid therapy if it serves to give the patient relief from his own anxieties; and it is effective if it supports his ego so that it may become functionally capable of handling current conflict situations. In many cases, the progress of psychotic symptoms to the point where hospitalization becomes necessary can be arrested and reversed. The writer has often observed profoundly disturbed patients, apparently headed for acute breakdowns, who recover sufficiently after a few months of therapy to become employable as well as socially functioning. Such patients remain under therapy in many instances for months or years. Much further improvement may not occur, yet these patients have continuing need for support which they will not relinquish. Treatment can thus become more or less interminable, continuing for years with the patient receiving no more than one or two interviews a month.

If the function of a mental hygiene clinic is to treat, to help emotionally disturbed people, to prevent hospitalization if at all possible, to give the healing power of time an "assist" and not think in terms of "curing"; then certainly the clinic is performing a useful function, even though there may be patients on its roster who rely on the "support" of the clinic for years.

It may nevertheless be asked: Should the clinic be more selective of patients? Would it be more worth while and economical to place under treatment only those patients who can be benefited by in-

sight therapy; and consequently to employ only psychotherapists with dynamic orientation or with psychoanalytic training, in order to provide what psychoanalysts hold to be the only real psychotherapy?

There are clinics of this type; but their case loads are limited, and it remains questionable whether their results are better than those of other clinics. The writer has had contact with patients who have had extensive therapy in such clinics and has been impressed with the many poor results of "insight" therapy. Others have also noted the frequent ineffectiveness of this approach, although analysts will counter that patients of the type described have not achieved true insight and that therapy in these instances has been "incomplete." This may be true, but it may also be true that in many such instances "true insight" will never be achieved! Perhaps the therapist is seeking to "cure" when it might be wiser to be content with just helping the patient make a better adjustment and attain some measure of comfort.

With the excessive demand for treatment that the Brooklyn Regional Office clinic receives, insight therapy for every case, as applied in the rigid sense, is not only impractical, but impossible. Even if enough properly qualified analysts were available, it would still be doubtful that the end result would be any better than it is now. Kenneth E. Appel and his co-workers in a recent survey[3] point out that in statistics and observation of therapists with differences in theoretical approach, there is impressive similarity of results. So outstanding an analyst as Knight[4] points out that there are actually no worthwhile statistical data from psychoanalytic experience by which one can judge objectively such a factor as outcome of therapy of patients under psychoanalytic treatment over the country; and that psychoanalysts do not seem to be willing to act like other scientists and medical men by pooling their data. He wisely stresses the point that psychoanalysts should keep their minds "constantly open to new observations, new conceptions, revisions of hypotheses, and testing and retesting of the revisions."

One can only wonder about some of the claims regarding the effectiveness of treatment and the results of their therapy made by certain less well-known analysts!

III

With these thoughts in mind, a review has been attempted of the performance of the various psychotherapists employed at this clinic. During a six-year period, a total of 32 psychiatrists have functioned in the clinic as psychotherapists for varying lengths of time. None of these physicians has been appointed to the clinic as a psychotherapist without evidence of training or experience (preferably both) of such nature as to indicate that he had a knowledge of psychodynamics and personality development with prior practical experience in psychotherapy.

The 32 psychotherapists have been divided into two general groups; those who utilize an "analytically-oriented" therapy and those who do not, or say they do not.

There have been 19 "analytically-oriented" therapists, who have been further subdivided into three sub-groups, which will be explained later.

The 13 remaining therapists, forming the second general group, have been arbitrarily labelled the "eclectic" group and include a variety of background, training and experience. The group is heavily weighted with psychiatrists who have had extensive state hospital or Veterans Administration hospital experience, neurological training, and contact with centers stressing psychobiological principles.

An attempt has been made to classify these two groups of therapists from the point of view of effectiveness as therapists. As administrator of a clinic in daily contact with its psychiatrists and patients, and in the course of time knowing the physicians rather intimately, as well as many of their patients, the writer believes that an objective judgment is possible as to the value of the therapist to the clinic and his effect on his patients. For simplification purposes, a therapist may be regarded as "very effective" or "satisfactory." The term "satisfactory" is used arbitrarily, and in certain instances may be regarded as unduly optimistic.

The criteria used to judge a physician's effectiveness as a psychotherapist consist not only of personal knowledge of him, but also of such factors as review of treatment records, interviews with many patients (often as a result of complaints), case seminar impressions, the status of patients who reapply for treatment after discharge as "improved," and not the least important, the opinions

of fellow therapists and visiting teaching consultants in psychiatry.

1. This group includes the 19 psychiatrists who are analyticaly-oriented or trained. Utilizing the previously noted categories of "very effective" and "satisfactory," the impression as to effectiveness follows:

Very effective	10
Satisfactory	9

According to this breakdown, a little more than 50 per cent of these therapists can be regarded as especially effective in treatment.

A further subdivision of these 19 therapists into three subgroups has been made as follows:

a. Nine therapists with formal analytical training at a recognized institute of analysis, who have been or still are in training:

Very effective	4
Satisfactory	5

In this group less than 50 per cent have been considered definitely effective in their therapy.

b. Three therapists without formal analytical training, who have experienced or are still undergoing a personal analysis:

Very effective	2
Satisfactory	1

The group is small and the reasons for undergoing personal analyses are not given, though they may be therapeutic. Nevertheless, two out of the three therapists have been known as highly effective.

c. Seven therapists without formal training or personal analysis, but who through prior residency training, study and conviction utilize analytic principles in their therapy:

Very effective	4
Satisfactory	3

In this group, over 50 per cent are considered to be particularly effective as therapists.

2. The general group of 13 therapists, described previously as 'eclectic," have provided the following breakdown:

Very effective	7
Satisfactory	6

The very effective therapists in this group total a little over 50 per cent.

The general impression from the data presented is that it makes little difference, if any, whether the therapist is analytically oriented—as far as effectiveness in treatment is concerned. Certainly in this admittedly limited study, the analytically-trained or analytically-oriented therapists have not provided any better therapy or any better results than those not so trained or so oriented.

* * *

It may be of some interest to consider the effectiveness of the 32 therapists described, in relation to the factor of prior residency-training in psychiatry.

1. Therapists with formal residency training of two to three years, which includes grounding in analytical principles:

Very effective	7
Satisfactory	7

Only 50 per cent of these therapists were regarded as providing effective therapy.

2. Therapists with no background of formal residency training in psychiatry:

Very effective	10
Satisfactory	8

In this group, more than 50 per cent of the 18 therapists concerned, provided effective therapy.

One may conclude from these data that formal residency training in psychiatry does not necessarily produce better therapists.

* * *

It may also be of some value to consider the effectiveness of the five psychotherapists who have a background of neurological training and experience:

Very effective	4
Satisfactory	1

Though only five therapists are involved, one may conclude that the discipline of neurological training and experience is certainly no handicap as far as effectiveness in therapy is concerned.

IV

The writer, having known these therapists rather well, feels that it may be of some value to speak in general terms of some of their personality attributes, particularly among those described as "very

effective," regardless of such considerations as prior background, training or experience.

In general, these men impressed the writer as "warm" individuals, with a real interest in their work, as well as confidence in their ability as therapists. It is likely that their confidence and assurance make themselves manifest to their patients. They are generally not intent on "curing" people, nor do they approach the mission of psychotherapy with "messianic" zeal. On the contrary, most of them approach their patient-problems with patience, humility and a desire to understand. One characteristic they seem to have in common is a sort of surface objectivity, which permits them to appear at least to be able to keep their own emotional reactions toward their patients under control. The result is that they do not betray their feelings toward patients.

Some of the more ineffectual therapists observed seem to have very strong feelings about their patients, either pro or con. They cannot be objective in dealing with their patients. They demonstrate either an attitude of close identification with the patient and his problems, or a rejection of the patient, which the patient probably senses. It does not appear to make any difference whether the therapist is or is not analytically trained, for him to fall into this category. Several therapists have had extensive formal training in analysis as well as personal analyses and still clearly demonstrate these characteristics in relation to patients, and in consequence perform poorly as therapists, despite their training and presumed "maturing" under analysis.

Appel and his associates,[3] in seeking common denominators of therapy that "really matter," emphasize a patient-therapist relationship based on certain common features which this present author feels are worth repeating: 1. A well-motivated patient. 2. A therapist who genuinely wants to help him. 3. The therapist's belief in the effectiveness of his treatment. (The patient is aware of it!) 4. The patient-therapist relationship is a living experience for the patient. (Mere intellectual formulation and interpretation do not produce improvement.) To these points by Appel, one may add that the therapist must be qualified for his role not only by reason of training, knowledge and experience, but also by personality.

Seventeen of the therapists concerned in this study were employed on a part-time basis and simultaneously carried private psychiatric practices. It is interesting to record the opinions and attitudes wherein they made comparisons between psychotherapy in private practice and psychiatric clinic practice. Their opinions and comments were not obtained by formal questioning, but rather by means of inadvertent remarks, informal chats, and in some instances through attitudes clearly expressed to mutual acquaintances.

It must be understood that all psychiatrists employed by the Veterans Administration are recompensed for their services, the "part-timer" being paid in proportion to the amount of time employed and to his grade, the latter being dependent upon his qualifications.

A number of them freely admitted that it is distinctly more satisfying to be paid for specific "patient-service" rendered, than just to be on a payroll. They appeared to have more enthusiasm for their private work for this reason. If this is true generally, one can well imagine the proportionate lack of enthusiasm among many psychotherapists in clinics which do not pay physicians for services or simply make token payments.

In general, it was agreed that patients in private practice were better motivated for treatment and by and large were more suitable for psychotherapy. These factors served to make private psychotherapy more gratifying for the therapist who could anticipate a reasonably good result for a given effort.

Some of the therapists felt that much of the poor motivation demonstrated by many patients in a "free" psychiatric clinic is due to the fact that they are not required to pay for treatment. The patient does not appreciate the value of the help offered him and feels no particular financial pressure in relation to the therapy applied. He doesn't have to "put out"; and this may very well have some impact on effectiveness of therapy.

Some therapists admittedly found it difficult to adjust to a clinic arrangement, preferring to work independently in a private office without having to feel any responsibility to an "employer" or to an organization of any kind. A number of these, generally regarded as excellent psychotherapists in private practice, rated only "satisfactory" in the clinic setting. It appears that not every physician

is suited for clinic work or capable of adjusting and willing to adjust to it. This brings up the problem of selection of psychiatric personnel for a mental hygiene clinic and may be worth more careful study.

V

Some comment regarding the roles of social workers and psychologists is in order.

The Brooklyn clinic has been fortunate in having a full complement of social workers, most of whom have been reasonably qualified for psychiatric social service. Their most important role has been at intake. Experience shows there is a better-motivated patient for therapy when the social worker has made a preliminary contact with the patient. In addition, a good "intake" saves the therapist much valuable time usually needed to introduce the patient into therapy. Likewise, an experienced social worker can screen out certain very poorly-motivated patients, as well as patients for whom therapy is not feasible, and direct them toward other resources. This economizes on the time of the therapist and may more properly serve the patients concerned. It is also true that many problems arise in a clinic which are purely in the realm of social service and are effectively processed only by social workers.

However, there are psychiatric social workers who apply themselves to their "case work" in such a manner as to cause one to speculate as to whether their counseling does not constitute an attempt at psychotherapy. There are even some who feel rather frustrated and limited in their present roles, and are ever ready and willing to assume frankly the function of therapist. Their zeal to counsel and "treat" often seems directly proportional to the quantity of psychoanalytic literature studied and consumed. Among varied blessings, one can now include "dynamically-oriented" social workers.

Since the Veterans Administration is active in sponsoring training programs for psychologists, this clinic, like many others of the large Veterans Administration psychiatric clinics, has always had a full complement of psychologists and psychology trainees. Their basic and most valid role has always been that of psychologic testing. This has been valuable for prognostic as well as diagnostic purposes. The writer's practice has been to restrict the testing to

a time either prior to therapy or early in the therapeutic situation. When done at a late stage of therapy, it may be threatening, or even traumatic, to some patients.

In this clinic, psychologists may do therapy with selected patients under supervision of psychiatrists. The big problem has been to know where to draw the line, which patients to select and whether to limit this work to certain of the more qualified and more mature clinical psychologists, some of whom have demonstrated considerable aptitude for therapy. In the writer's experience, most psychologists want to treat patients, but unfortunately many do not recognize their limitations. Some have been rather young and immature, with more enthusiasm than judgment. In therapy, they have been too quick with explanations and interpretations, at times with disastrous results. Others have been too "directive," and have not permitted the patient to set the pace, as he frequently must. Real supervision of therapy by a psychiatrist who is qualified to assume such a responsibility, is time-consuming and difficult when applied to non-medical people trained in a discipline, which, though related to psychiatry, has nevertheless a distinctly different emphasis and approach.

It can only be emphasized that psychotherapy is essentially a medical function and should be the exclusive responsibility of the physician who is trained in psychiatry and in psychotherapy. Of all the forms of medical practice, it is probably the most difficult, and certainly the most personal, of techniques. When mishandled by poor therapy, the patient may be seriously hurt. One hopes that time will quickly bring more adequate medical safeguards to the entire problem of psychotherapy, with better selection criteria as to who should and who should not enter the field, as well as greater understanding of its techniques and mechanisms.

Summary and Conclusions

1. Psychotherapy in a mental hygiene clinic faces many problems not encountered in private practice. One of the greatest problems is that of poor motivation for treatment on the part of the patient as well as lack of sufficient enthusiasm on the part of the therapist.

2. Outpatient clinic psychotherapy is of necessity largely "supportive" in nature. This is nevertheless sound, in that, by this

means, patients get relief from their anxieties as well as support, so that at the very least they may remain employable and socially functioning.

3. Mental hygiene clinics reduce the need for hospitalization in many instances.

4. In an outpatient situation, analytically-trained and oriented therapists apparently do not provide any better therapy or produce better results than therapists not so trained or qualified.

5. Formal residency training in psychiatry appears not to have produced better therapists as far as the experience of this clinic is concerned.

6. Intangible factors such as the personality of the therapist and the latter's attitude toward the effectiveness of his treatment, are vital elements leading to good results.

7. Psychotherapy is a medical function and responsibility.

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EVIL EYE IN MYTH AND SCHIZOPHRENIA*

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Introduction

The occurrence of analogous correlates between the thought content in schizophrenia and the mythological and magical data of primitive cultural groups and prior civilizations has been known for some time. It was such analogies that led Jung to the postulation of the existence of primordial images or archetypes in a collective unconscious.[1] The schizophrenic patient regresses to a primitive, concretistic, so-called archaic or magical thinking, in which the boundaries of the ego are lost (the *participation mystique* of Levy-Bruhl) and many delusions of occult and demoniacal influence develop.[2] He may believe that he possesses powers of telepathy and clairvoyance, that harmful spirits are entering his body and torturing him, or that he has a cosmic mission to fulfill. Magic is utilized to maintain the preservation and security of the ego. Such occult and demoniacal concepts form an integral part of primitive cultures and prior civilizations, as well as many of the superstitions of our own age. Occasionally the schizophrenic patient believes that magical power can even be conveyed by a glance, at which times he may believe himself to be the possessor of the evil eye or influenced by it. In this inquiry, the concept of the evil eye will be studied in terms of the mythological data, case material and its symbolic value.

Evil Eye in Myth

The myth of the evil eye dates back to antiquity and is universal among cultural groups. Arising from primitive magical philosophy, a power of evil was believed to emanate from the eye in a glance of enchantment or bewitchment by one possessing a superior spirit and having diabolic intent to influence, subdue or control weaker spirits.[3] In the ancient and medieval worlds, such a power was spoken of as fascination (*oculus fascinus*)** and is known in

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**The term "fascination" was originally used to denote the evil eye in a non-technical sense until the eighteenth century. At that time it became associated with animal magnetism; and, then, during the nineteeth century, the word lost its occult significance.

Italy as *jettatore*. Two kinds of fascination were believed to occur. A good or white fascination resulting from love, and a bad or black fascination, the result of the evil eye, having its origin in emotions of envy and hate. Also, it was believed that one might possess the evil eye and do harm without even being aware of the possession of such a diabolic abnormality, a case which is referred to as involuntary fascination.

The effects of the evil eye were thought to be widespread. Gods, as well as devils, used the evil eye to produce these effects on other gods and men. Individuals with some physical abnormality, particularly an ocular one, were presumed frequently to possess the power of fascination. Animals, both real and mythological, were often regarded as diabolic fascinators. Frequent references are made to the stiffening power of the glance of the serpent, and the penetrating stare of the wolf. Many diseases were credited to the evil eye, including ophthalmia, trachoma, colic, yawning, hiccoughs and fever. Predisposition to the evil eye was believed common, and marked susceptibility was characteristic of children, women, pregnancy, nursing mothers and the nuptial period. Praise, admiration, envy and boastfulness often were thought to precipitate fascination. Hence parents avoided praise and admiration for their children so they would in no way be affected. The ancients assumed that women had more power of fascination than men, while more comparatively modern authors have expressed an opposite conviction.

This belief was first recorded historically in Babylonia, where fascination was regarded as being etiological for most diseases. The Gilgamesh Epic speaks of the demon *utukku,* who by a mere glance could cause injury to a man.[4] The Egyptians believed in the evil eye, and the eye played a very important role in their mythology as illustrated in their deification of Ptah,[5] who was said to be the father of gods and men. He was believed to have brought forth all the gods from his eye, and men from his mouth, illustrating the potency applied to the emanations of the eye. The Egyptians drew two large open eyes on their sarcophagi as a reflective defense against the evil eye. In the Bible, many condemnatory references are made to the evil eye.[6] For example, "Eat thou not the bread of him that hath an evil eye" (Proverbs XXIII:6).

Greek and Roman mythology and literature abound in references to the evil eye. Plato[7] (429-347 B. C.) gave attention to this belief

when he had Socrates state, "Nay, my good friend, let us not boast lest some evil eye should put to flight the word which I am about to speak."[7] Heliodorus of Emesa (third century B. C.) stated that "when anyone looks at what is excellent with an envious eye, he fills the surrounding atmosphere with a pernicious quality, and transmits his own, envenomed exhalations into whatever is nearest to him."[8] Philostratus, in his biography of Apollonius of Tyana (first century A. D.), recorded that the famed magus possessed such wonderful eyes that he could kill with a mere glance.[9]

In Rome, Pliny (23-79 A. D.) reported that special laws were directed against fascination. He told of certain women who could kill men and cause plants to wither by mere glances. "Isigonus adds, that there are among the Triballi and the Illugri, some persons of this description, who also have the power of fascination with the eyes, and can even kill those on whom they fix their gaze for any length of time, more especially if their look denotes anger."[10] He spoke in a naïve fashion of the fascinating qualities of the mythological "Catoblepras," "In the eastern part of Ethiopia . . . dwells a savage beast called the Catoblepras, small in size and slow of movement and with a head of disproportionate greatness . . . The animal has eyes which are fatal to mankind, for all on whom it looks fall suddenly dead."[11] Plutarch (46-120 A. D), in his *Symposiacs,* expressed his belief in the evil eye by relating: "We know that some men by looking upon young children hurt them very much, their weak and soft temperature being wrought upon and perverted, whilst those that are strong and firm are not so liable to be wrought upon . . . For the sight, being very vigorous and active, together with the spirit upon which it depends, sends forth a strange fiery power; so that by it men act and suffer very much, and are always proportionately pleased or displeased, according as the visible objects are agreeable or not."[12]

In Persia and India the belief in the evil eye has persisted to this day. In ancient Persian mythology, the 99,999 diseases believed to afflict man were ascribed to the evil eye of Ahriman, the Persian devil.[13] In western India, all witches and wizards are said to be possessors of the evil eye. The Hindus, in most cases, believe the evil eye is the result of covetousness. They think that foreigners have a special predisposition to fascination, and when appearing before an English magistrate, they gaze at the ground in order to avoid the evil influence of his glance.[14]

Credence in the evil eye persisted throughout the medieval world. The numerous epidemics of plague, smallpox, cholera and other diseases were often ascribed to the evil eye. The contagion was thought to be transmitted from a glance of one afflicted. Monks were frequently believed to possess the evil eye. Alexander Neckam (twelfth century), the foster brother of Richard *Cœur de Lion,* told of the fatal glances of the basilisk and wolf, explaining that fascination is due to evil rays from someone, who looks at you.[15] The Dominican, Thomas of Cantimpré (thirteenth century), reported that "a man who is seen first by a wolf cannot speak," arguing that the rays from the wolf's eye dry up the *spiritus* of human vision which in turn dries up the human *spiritus* generally.[16] Albertus Magnus (thirteenth century), famous as scholar and magician, spoke of fascination as an example of occult influence exerted by one man over another, and referred to the belief of Avicenna and Alogozel in this practice.[17]

Thomas Aquinus (thirteenth century) regarded fascination as a fact and explained it as being due to the power of the evil eye.[18] He stated that the eye is affected by a strong imagination of the soul and then it corrupts and poisons the atmosphere through the glance so that tender bodies coming within its range may be affected. Roger Bacon (thirteenth century) was skeptical, regarding fascination as a "stupid notion characteristic of magic and old wives and beneath the notice of philosophers."[19] However, he did believe in "marvelous fascination." Peter of Abano alluded several times to the subject of fascination, but denied the importance of visual rays, or the evil eye, in a literal sense.[20]

In the *Malleus Maleficarum,* textbook of the Inquisition, several references are made to the evil eye:

"It may so happen that if a man or woman gaze steadfastly at some child, the child, owing to its power of sight and power of imagination, may receive some very sensible and direct impression. An impression of this kind is often accompanied by a bodily change, and since the eyes are one of the tenderest organs of the body, therefore they are very liable to such impressions. . . . And so it may happen that some angry and evil gaze, if it has been steadfastly fixed and directed upon a child, may so impress itself upon that child's memory and imagination that it may reflect itself in the gaze of the child and actual results will follow, as, for example, he may lose his appetite and be unable to take food, he

may sicken and fall ill. . . . There is a great power in the eyes, and this appears even in natural things. For, if a wolf sees a man first, the man is struck dumb. Moreover, if a basilisk sees a man first, its look is fatal."[21]

"There are witches who can bewitch their judges by a mere look or glance from their eyes and publicly boast that they cannot be punished; and when malefactors have been imprisoned for crimes, and exposed to the severest torture to make them tell the truth, these witches can endow them with such an obstinacy of preserving silence that they are unable to lay bare their crimes."[22]

The Renaissance saw the publication of several works on the evil eye, mainly *De Fascino* of Varius, published in 1589, Delrio's *Disquisitonum Magicarum,* 1603, Gutierrez' *Opusculum de Fascino,* 1653 and Fromman's *Tractatio de Fascinatione,* which appeared in 1674.[23] Varius is quoted by Burton, who had a firm belief in the power of fascination, as stating that the "visual spirit, which is in certain cases of an evil nature, affects the eyes of a person glanced at by piercing them with poisonous rays."[24] Delrio emphasized that a diabolic bond was involved. "Fascination is a power derived from a pact with the devil, who, when the so-called fascinator looks at another with an evil intent, or praises, by means known to himself, infects with evil the person at whom he looks."[25] Gutierrez, a Spanish physician, believed that fascination produced a characteristic medical syndrome in which there was loss of color, heavy and melancholy eyes with tearfulness or an unnatural dryness, frequent sighs, a depression of spirits, apprehension, bad dreams and a loss of weight. Coral or hyacinth worn by the afflicted was believed to lose its color and a ring, made of the foot of an ass, put on his finger, would grow too big for him after being worn for a few days.[26] Here we have several laboratory tests to prove the presence or absence of fascination. The study of Frommannd, a physician of Saxe-Coburg, is encyclopedic in its scope; he discusses susceptibility, the symptoms and therapy of the fascination process.

Cornelius Agrippa, the 16th century occultist, an older contemporary of Paracelsus, expresses his belief in fascination, in his *Occult Philosophy,* when he states:

"Fascination is a binding or charm which passes from the mind of the sorcerer through the eyes and the heart of the one he is bewitching, and sorcery is an instrument of the mind—from the

purest blood engendered by the beat of the heart, which does continually send rays of a like nature through the eyes. You must know, therefore, that men grow bewitched when they look continuously straight into the eyes of another, that the eyes of the two then fasten themselves strongly to one another, and light of eye also to light of eye; mind then joining to mind and carrying flashes to it and fixing them upon it."[27]

The author of the famous poem, *Syphilis sive de morbo gallico*, Fracastoro (1478?-1553), contributed much to the theory of contagion and distinguished three categories of infection; the first one contact, the second fomites and the third infection at a distance. He included the evil eye under the third category.[28] He relates, "Thus a patient with ophthalmia may give his disease to another by merely looking at him. . . . This well illustrated the rapid and almost instantaneous penetrative power of this type of contagion . . . which may be compared to the poisonous glances of the catablepha."[29] However, he hastens to remind us that "the cause of infection at a distance need not be referred to occult influences."[30]

Francis Bacon, the propounder of the inductive method, was not one to scoff at fascination. He states that "there be none of the affections which have been noted to fascinate or bewitch, but love and envy. They both have vehement wishes; they frame themselves readily into imaginations and suggestions; and they come easily into the eye, especially upon the presence of objects which are the things that conduce to fascination, if any such thing there be."[31]

Further works on the evil eye, proclaiming belief in its occurence, appeared during the early part of the nineteenth century. Francis Barrett, the English occultist, published *The Magus or Celestial Intelligence*[32] in 1801, a chapter of which is devoted to "The Art of Fascination, or Binding by the Look of Light," in which is discussed the power of the witch to afflict with an evil glance or look. In a two-volume treatise, Valletta[33] did research on the subject involving the influence of sex on the efficacy of the fascination; whether peruke, tobacco and spectacles increase its efficacy; the influence of pregnancy; of priesthood; the distance and direction from which the eye's glance is most powerful; means of detecting possession of the evil eye, and remedies for it.

Belief in the superstition persists today, particularly in peoples of Mediterranean extraction and in rural areas and small towns.

Many Italians and Greeks, usually those of limited education, still believe in the power of *jettatore.* Frequently farmers attribute failure in crop production or the death of an animal to the evil eye. In January 1934, the *London Daily Express* told of a man, living in a Dorset hamlet, who was fascinated and hence was slowly wasting away.[34] He had been repeatedly examined by physicians and was pronounced medically well.

The evil-eye superstition remains common in primitive cultural groups. The Bantu people speak of *kitamengo,* referring to one possessing the evil eye.[35] They suspect this when an animal becomes sick after having been admired or envied by a neighbor. With the Shilluk, "the power of harm is made operative by looking fixedly at the person to be made the victim. The person exercising the power is usually in anger when the deed is done. The person who is bewitched says, 'the eye went into,' and if the person who did the deed speaks of it, he will usually say that his eye went into the other."[36] The Azande refer to a wizard as one possessing the evil eye, which they believe to be transmitted by heredity from sex to sex.[37] The evil eye is particularly dreaded by the Malays, who think certain people are able to produce ill luck by a glance, toward which children are especially predisposed.[38] The Orakaiva sorcerers need only fix an eye on an intended victim to make him fall ill.[39] In Eddystone Island, of the Solomon group, the *nyrama,* a man with the evil eye, causes a throat disease with hemorrhage and rapid death by magically devouring one's insides.[40] The natives of the New Hebrides believe the evil eye readily pierces the openings of the body in a destructive fashion, particularly those of the genitalia, and hence men are very careful to keep the penis, and women the vulva, well protected.[41]

Many defensive measures were established to ward off the influences of the evil eye. No other superstition has produced such a large and varied assortment of defensive charms, amulets and gestures.[42] The Eye of Osiris as emblem and amulet was used against fascination by the Egyptians. The Persians and Greeks utilized Medusa's head as an amulet. Though the eye, contorted faces and masks were almost universally used to ward off the power of the evil eye, sexual symbols were the most common and were believed to be the most potent defensive measures.[43] Many of the amulets pictured obscene gestures, such as the *manus obscaene,* in which the thumb is protruded between the first and the

second fingers."[44] The sexual symbolization was almost invariably phallic, and these phallic symbols were conveyed in the central position of the compounded amulets.

In summary, the belief in the evil eye is universal and is attributed to an ejaculation of evil power from the eye of the fascinator. The evil eye is associated with the affects of envy, hate, boastfulness and admiration; infants and children are particularly susceptible to its influence. Phallic symbols are the most commonly used defenses against its power.

Evil Eye in Schizophrenia

Three patients suffering from schizophrenia have been studied in regard to the clinical manifestations and symbolic meaning of the evil eye.

Case 1

A 29-year-old man was brought to Colorado Psychopathic Hospital because of aggressive and hostile behavior toward his father. It is reported that after he beat his father about the face with his fist, he began mumbling something about an "evil eye" and about eyes staring, and attempted to apologize to his father by shouting to the world, "I have a good father. He has never done me any wrong. He is the best father in the world."

The patient was in an acute confusional state on admission. He was seen to fix his own eyes on the eyes of everyone he saw and he would become combative with his fists and hands as if he wanted to pluck the other person's eyes out. He often suggested to these other persons that he would like to remove their eyes because they belonged to someone else. He himself showed a decrease in the amount of his own blinking, but there was normal reaction to any threat of harm to his eyes.

Three days after admission the patient seemed to come more markedly into contact with the environment and at this time he was asked what significance eyes had to him. He revealed that he had begun masturbating at 16 and felt that someone was watching him. He thought this person was his father. He declared that the eye represented to him a portion of the body which had passed through all the generations of his family, and that within this eye was a pupil which expanded and contracted, and, on expanding, revealed the image of Jesus Christ. Also, according to his belief, a strange

catastrophe was about to fall on the earth in which two opposing forces would go about destroying the world. He felt that the eye with its pupil and the image of Jesus, which was now in his possession, must be introduced at the opportune and absolutely correct moment, and that, if this were done, the world catastrophe would be averted.

Psychotherapeutic investigation of this case revealed a marked ambivalent relationship with the father, toward whom the patient had intense aggressive impulses. However, his guilt over these impulses was marked, as well as guilt over his Oedipal strivings, for he feared the father would see him masturbating and would harm his genitalia; he felt strong fears of castration. This was well brought out in one of his dreams, void of symbolic elaboration as the dreams of schizophrenic patients frequently are, in which he was actually being castrated by an older man, whom, in his associations, he identified as his father. His attempt to strike and pluck out the eyes of the physicians and attendants represented his retaliative strivings and aggression directed toward his father and his attempts to castrate his father symbolically in order to avoid his own castration. Christ and the crucifixion symbolized castration to the patient, and through redemption with the Christ of the collective eye, that is the eye which had been passed through all the generations of the family, he would be able to reconcile himself with his own father. In turn, the world catastrophe, which represents the struggle for omnipotence between him and the father, would be avoided and the patient subsequently freed of castration and guilt.

Case 2

A 27-year-old, married woman was first seen in her home by a public health nurse who had been called because of a disturbance that had been heard by the neighbors. When the nurse arrived, the patient flung her arms around her neck and expressed the idea that people were after her. She told the nurse that a male employer had first concentrated with his eyes on her left eye and then had concentrated on her right eye, then on both of them, in order to take her brains out. She had had her eyes examined only a few days before the acute onset of her disturbance because she thought that something was happening to them. She said to the nurse, "That man is after my eyes again," as she covered her eyes with her hands in a protective manner.

On admission to the hospital, this story was clarified, in that she felt the manager of an office at which she had worked had been influencing her with his eyes and that she had been hypnotized by his eyes. She felt that she was being watched carefully and was being punished for all her previous mistakes, which she referred to as "monkeying around" with her "privates." She asked the doctor how it was possible for him to have such great powers of cure over her by using his eyes and stated that she knew that this was the only way the therapist was helping her. She thought that he was replacing in her brain with his eyes what the employer had tried to extirpate from her. She also believed that her own eyes were going to be taken away from her because she had misbehaved. Because her abdomen was protruding, she thought herself to be pregnant. She was afraid that therapy would lead to abortion and sterility. Auditory hallucinations in which she heard her previous employer say that she was crazy and needed to study psychology occurred. This voice also told her that it was going to tear out her eyes and her brains because she had misbehaved. The previous employer was described as tall and dark, much as she remembered her father.

Interviews with this patient revealed that her fear of influence through the manager's eyes was related to guilt over early masturbatory experience ("monkeying around with my privates") for which she felt she would be punished through the loss of her vision. She would frequently cover her eyes with her hands to protect them from any injury. The fascinator (the manager) was equated with her father; and his power of the eye represented the taking of her eyes for misbehaving, which in turn symbolized her own castration fears (a displacement from below upward) over her sexual indulgences. Therapy revealed that the sexual experiences were not only masturbatory experiences, but also involved unwilling coitus with an uncle and several older men, who were father imagos to her. Her own father was an alcoholic during her infancy, and she repeatedly searched for a father imago throughout her life. For her, the eye symbolized the genitalia. The therapist was a "good father" to her; she began to feel herself restored; and then castration was no longer a danger. She believed that he was replacing in her body what the "bad father" had taken away from her.

Case 3

A 32-year-old registered nurse was admitted to hospital in a confused state in which she vascillated between complete absorption in her delusionary activities, which created an aura of brightness and happiness about her, and a state of partial reality which produced a great deal of anxiety. Her talk was usually conversational and logical, but at times would become irrelevant, rambling, interrupted, scattered with verbosity, indefinite conclusions and neologisms.

Among these ramblings she expressed the idea of a "private eye" (an actual eye, not a private detective) and developed this into the idea that her husband, from whom she was divorced, had "eyes of fear." These eyes were then transposed to other people, who were interpreted variously as prostitutes and relatives of honky-tonk performers. The eyes were also attributed to cats, and this was expanded into the idea of cat-people, violent cats, and cats that spring and kill.

About three weeks before her hospitalization, she became aware of a "private eye" that was watching her and directing her actions and thoughts. It was in a radio and it transmitted ions into her brain and told her "do and act as you want and don't let others influence your actions and thought." She felt that this had changed her whole life and believed the eye was put there to guide and watch her. She didn't know exactly who was behind it, but surmised that it might have been one or all of the following: the chief of police, the F. B. I., her brother, a doctor, the son of an elderly patient, or a mind healer who preaches over the radio on Sunday mornings. Communication from her to the "private eye" was not believed possible. In her delusions, the ions from the "private eye" entered her brain above the left eye, then passed to the area over the right eye where she interpreted the message.

The "private eye" was also able to draw tissues and vital body fluids from her. She thought that it built a new nasal septum for her and removed membranes from under her eyes. In a later action of the "private eye," she thought her uterus was being cauterized. This occurred without pain. During the cauterization, the "private eye" told her that "intercourse with brothers will lead to world peace." This "private eye" also worked on her telephone to prevent her from calling the police, doctors and others. She was aware of this because she could hear clicking sounds over the

telephone. She believed also that the physician and her boyfriend have a "third connection" in the form of another "private eye" through which they can control the one in her apartment.

The patient revealed in psychotherapy that she was unhappy in adolescence after the death of her father, and, therefore, married in order to have someone to take care of her as the father had. To her, the possessor of the "private eye" represented her husband, a father figure, as well as numerous other father imagos (physicians, and chief of police). The drawing out of tissues and vital body fluids by the "private eye" symbolized castration, and this was overtly expressed later in the delusions of uterine cauterization. She was injured because of her own guilt over intolerable sexual impulses and aggression toward her husband, which in turn, symbolized the conflict with her father. This was manifest ambivalently in the expression of an incestuous wish and in punishment for this wish: in the condoning of incest, and in cauterization of the uterus by the "private eye." The fear of the "private eye" or more properly, the evil eye, here represents castration as punishment for incestuous and aggressive strivings with the father.

Discussions

From the aspect of psychodynamics, a symbol is a representation of primary unconscious material in a concrete and sensorial manner of secondary significance; a connection between the primary and secondary elements occurs in some common characteristic. The idea symbolized is repressed, and relates almost invariably to the phenomena of birth, love or death; the vast majority of symbols have a sexual significance.[45] The eye is one of the commonest somatic sexual symbols.[46] In an early paper, Ferenczi[47] interpreted the self-blinding of Oedipus as self-castration by displacement. The phallic significance of the eyes has been noted by a number of observers.[48] The eye has also been interpreted as a female symbol, the pupil representing the vagina, the lids the labia, and the lashes the pubic hair.[49] Hence the eye may be interpreted as a penetrating or receptive organ. The eye plays an all-important role in visual sexual curiosity, and conflicts over this are integrally related to scopophilia.[50]

Aggression is frequently symbolized by the eye.[51] As is well known, the eye is regarded as the "window of the soul," and, hence, one's emotions are believed to be apparent in the expression of the

eye. Aggression is manifest in the idea of "looking daggers" at someone, at which time a penetrating, hostile glance appears in the expression of the individual. To avoid recognizing such expression, one frequently looks away from the hostile individual, so the eyes of the recipient will not know the effects of the hostile glance. At other times, one looks directly at the hostile individual in order to reflect his glance. Power and grandiosity, too, are represented symbolically by the eye. Children, when experiencing guilt over what the parents regard as misbehavior, frequently attempt to avoid the look and expression of the "powerful" parent or parent surrogates. The eye in many cultures symbolizes the sun, and from this extends to light, power, knowledge and deity in general. In ancient Egypt, the eye was the symbol of Horus, god of the sun, and of Osiris, god of the dead.

Delusions concerning the eye in schizophrenic patients are mainly of two types.[52] The first is that the characteristics of the patient's eyes, such as form and color are altered, and this change is allegedly apparent to others. In the second category, one finds delusions centering around belief in change of vision occurring in the patient, such as photophobia or diminished vision. In some cases, it is evident that the delusion is developed upon the idea that eyes transmit or receive evil influence. This was the nuclear delusion in the cases of the present study. In summary of the clinical material, the delusion of evil influence through fascination was found to symbolize punishment for guilt in regard to sexual temptations and activities, such as masturbation and coitus, which often had incestuous implications. In the punishment, aggression was manifest in sado-masochistic features, for example the delusion of uterine cauterization by the glance of the "private eye" (Case 3). Castration as punishment was apparent in the delusions and associations of the patients.

That interesting analogies occur between the case material and the myth of the evil eye, cannot be denied, even though these may have little or no causal relatedness. Many fallacies certainly exist in attempting to explain cultural phenomena in terms of individual psychopathology and in the equating of the primitive with the neurotic or psychotic. In the study of the evil eye myth, however, it is apparent that sexuality and aggression are significant determinants of the belief, just as they were determinants for the delusions of the evil eye in the patients suffering from schizophrenia.

In the superstition of the evil eye, one becomes aware of the significance of the eye as an organ of aggression. Many who possess this power of the evil eye, whether men or animals, are believed capable of killing or seriously injuring by a mere glance. The origin of the phenomenon is thought to rest in the possessor's feelings of envy and hate, which are characteristically expressed by hostility. Praise, admiration and boastfulness on the part of the recipient of the evil are thought to be precipitants of susceptibility. Such feelings frequently lead to the arousal of hatred and envy on the part of others, and these, in turn, to aggressive reactions, either overt or covert, by them. With the utilization of the projective mechanism, fear of the evil eye may represent the manifestation of one's own aggressive impulses attributed as being apart from the ego and acting in turn against it. A need for punishment because of guilt over hostility and aggression can be realized in the suffering of a recipient from the influence of the evil eye.

Sexual components of the evil eye myth are apparent overtly in the susceptibility associated with pregnancy, nursing, and the nuptial period, and in the numerous defensive measures, such as the use of amulets and gestures, which have a genital significance. The pregnant woman fears abortion, which represents infecundity, and the nuptial pair may fear impotence, frigidity or sterility. Both these experiences are therefore closely connected with feelings of sexual inadequacy and failure, which in turn are related to a number of psychological conflicts, particularly with castration anxiety and penis envy.[53] A tendency to abort, as well as difficulties during the nursing period, may be symbolically associated with strong feelings of penis envy, with its associated ramifications of masculine strivings and hostile rejective feelings toward the child.[54] Difficulties of the nuptial pair can frequently be related to castration anxiety in the male or penis envy in the female, or to a combination of both these factors.

The amulets as well as the obscene gestures, used as defenses against the evil eye, are most commonly of phallic significance. Jones has studied this problem and believes that the apotropaic qualities of the amulets and charms have been ascribed to genital symbols because of "first, the exaggerated association in the primitive mind between the genital organs and the idea of power or potency; and secondly, the fact that originally nearly all evil magical influences were imagined to be directed against the sexual or-

gans and their functions."[55] The charm is therefore used to show that the threatened genitalia are safe. The power motif of phallic symbolization undoubtedly plays a role in the magical qualities of an amulet, in that the wearer is able to identify himself with power and potency, and so be strengthened in his defenses against the evil eye.

The visage of Medusa's head in the amulet and charm was one special defensive measure used by the Persians and Greeks to ward off the influence of the fascinator. The decapitated head of Medusa, as well as the snakes surrounding it, has been interpreted by Freud[56] and Ferenczi[57] as being linked to visual awareness of the terror of castration and, therefore, in turn to the female genitalia. Such impressions brought suddenly to the awareness of the possessor of the evil eye, could arouse terror of bodily injury and castration in him and nullify his powers to execute fascination. What brings forth anxiety in one's self will produce the same effect in the individual against whom one is striving to protect one's self, in this instance, the fascinator.

The emotions of hate, envy and boastfulness also may be connected with sexuality, as these are common feelings that frequently come into awareness with sexual problems, particularly with the Oedipus complex.[58] The child experiences jealousy and hatred toward the parent of the same sex, because of the child's attempts to possess solely for himself or herself the parent of the opposite sex. Boastfulness becomes manifest as the child's attempt to overcome the feeling of being a child, that is, to overcome the narcissistic injuries of the Oedipus complex. It is interesting to note that children were thought to be particularly susceptible to the emanations of the evil eye. The idea of the conflict between the superior spirit, possessing the evil eye, and the recipient is analogous to the conflict between parent and child in the Oedipal situation.

The fantasied punishment for Oedipal strivings is castration. The injuries thought to be precipitated by the influence of the evil eye may be interpreted as symbolizations of castration. This idea is overtly expressed in the New Hebrides natives' fear that the emanations of the evil eye may pierce and harm the genitalia.[59] Jones has indicated that the dread of the *maleficium* of evil beings is associated with the fear of impotence and castration.[60] A similar dynamic structure is seen to exist in the schizophrenic patients studied here, who experience strong castration anxiety over sexual

impulses with incestuous connotations. In the defenses used against the evil eye, such as the use of amulets and charms, attempts to avoid castration are apparent in the symbolization of the power and potency of the threatened organ as well as in the attempts to shock and frighten the fascinator.

Summary

The occurrence of the concept of the evil eye in myth and schizophrenia has been presented in this study. The delusion of the evil eye in the cases studied was found to be psychodynamically related to aggression and sexuality with incestuous implications and castration as punishment. Similar dynamic factors were found to be operating in the myth of the evil eye.

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EDITORIAL COMMENT

TOUGH TEMPORA, WORSE MORES

There is reasonably good authority for the belief that when old Marcus Tullius Cicero stood before the Roman Senate and uttered the world's best-known complaint about the times and the customs, he did not have youthful misconduct in mind; Lucius Sergius Catilina was a 45-year-old political personage whose delinquencies included treason and murder. But it is a fair impression, though it might be ill-advised to attempt its defense statistically, that, of the tens of millions of times orators and writers have deplored the *tempora* and the *mores* since, the majority have been talking about the juvenile delinquent.

The memory of man runs not to the contrary; for uncounted thousands of years man has learned with surprise that the behavior of his young is reprehensible. The problem of juvenile misdeeds is as old as the problem of life and death. Each generation, as time rolls on, discovers with astonishment that there are juvenile delinquents among the youthful in its midst. Eventually, as time still rolls on, each aging generation discovers that the fault lies less with youth than with itself; it discovers that the condition is less serious than alarmists have painted it; and it concludes that the whole disorder is self-limiting anyway.

Our own older generation—that is the one born around A. D. 1910 (plus or minus 15)—has seen recurring examples. A statistician could likely chart a frequency curve, or an archeologist label the high points by sorting the debris, layer by layer. One could call the surface, or present layer, Post-war II delinquency, characterized by "comic" book and flying saucer mentalities. Underneath, one would find the remains of the brief but intensive outburst of Pre-war II delinquency, with its eat-drink-and-be-merry motivation in the face of the approaching storm. Then there was the delinquency generally blamed on the depression, with misbehavior credited to daily deprivation, poverty-caused "broken homes" and hopeless outlook for the future.

Somewhere along here belongs Philip Wylie's *Generation of Vipers,* in which all, all are delinquent, adults as well as juveniles. And just before the depression years, came the racketeering era

during prohibition, when some of the most flamboyant delinquency of the century spread like colon bacilli in sewage; the juvenile bad man naturally adopted the patterns of his gangster elders; the Capones built their underworld empires on the ruthlessness of 'teen age, or little older, gunmen. The subdivision one might call Post-war I delinquency came at the beginning of the rum-running period; delinquent youth miscalled itself a whole "lost generation" and devoted itself to hedonistic misbehavior. Its disapproving elders had not so many years before been heartily disapproved of in their turn for wicked ways that were attributed at the time to such things as cigarette smoking, the craze for ragtime music and the pernicious influence of that immoral invention, the movie, shown throughout the country in dens of iniquity known as nickelodeons. To complicate these two early phases was the newly popular automobile, the sign and symbol of disrupted family life, the lure to recklessness and the instrumentation by which hordes of innocent girls became fallen women.

It makes sense once in a while to recall the once-familiar injunction of Al Smith and "look at the record"—where delinquency is concerned in the present instance. "Unless we forego the curses and get down to cases," says Medical Director George S. Stevenson of the National Mental Health Association, "the current hysterical excitement about juvenile delinquency will produce nothing more than fear, fury and a flock of new investigations which will come up with the revolutionary discovery that juvenile delinquency is a problem."

It would be interesting, though perhaps futile, to make a start by an attempt to find the bases of the "current hysterical excitement." There are plainly no definitive answers and no simple relationships. One may, nevertheless, add together some of the matters that have aroused public discussion of late, with some certainty that if the result does not explain delinquency, it may explain some of the present uproar about it.

One might begin by noting that relative increases in apparent delinquency—and probably in real delinquency—seem to follow sweeping war efforts. The effects in defeated countries are, of course, much more marked than in victorious ones; gangs of child criminals gave serious concern in both Italy and Germany after World War II. Similar phenomena, though of less relative extent, were noted in France, Great Britain and the United States. The

absence of fathers, permanent disruption of families and cramped living quarters during war, with severe economic adjustments following war, are among the commonly-noted superficial reasons for increases in juvenile delinquency in victorious countries. Much the same sort of thing, those with long enough memories will recall, followed World War I, although the manifestations were less marked, as distress was less extreme; and, in the United States, the extent of Post-war I delinquency was masked to some extent by the greater delinquency attributed to prohibition.

It might be an intelligent guess that the "hysterical excitement" that accompanied increases in delinquency after both wars—and on other occasions—is largely the expression of unconscious but extreme guilt by the adults who feel themselves responsible for the conditions under which delinquency arises.

From slum environment to crime comic books, the list of "causes" to which delinquency itself is currently attributed is long. And strong cases for any one of them can be made out, if the public, which must judge, does not restrain its impatience for easy and superficial answers and does not constantly remind itself that the evidence is not only not all in but that in the nature of things it probably never can be all in. It is difficult enough for even the trained and skeptical scientist to see the forest instead of the trees. The horror comic book, for a present instance, is now throwing a shadow which conceals a whole grove of causes behind it.

It may be safely supposed that no psychiatrist who has actually seen one of the revolting things would defend seriously the horror comic as entertainment for youth. There is, in fact, rather sickening sophistry in defenses of this sort of thing as productive of harmless thrills, or as providing a socially-acceptable outlet for "natural sadism."

But the point may be made, with equal force, that to attribute all or the greater part of a major outbreak of delinquency to the comics is to show as great a lack of balance or proportion as it is to uphold the rotten things. One can very well understand how Dr. Frederic Wertham, for example, drawing on years of psychiatric contact with delinquents and their misdeeds, is impelled to write a documented, blazing indictment of the horror comic as doing vast harm to our children. His child behavior patients and child criminals displayed close acquaintance with such publications; and some of them aped comic book characters in their crimes. But the

clinical evidence that the comics are chiefly to blame, or even are largely to blame, for juvenile delinquency is less than convincing. For one thing, there are no satisfactory controls; we have no way of knowing how many non-delinquent children read the same comics that the delinquents read, or how they are affected by them; and the results of any attempt to find out would almost surely be even less reliable than the Kinsey sex survey figures.

The speculations most psychiatrists would make as to those two matters are not, however, that crime and horror comics are generally incentives to delinquency. While we do not know how many non-delinquent children read the worst comics, we do know that the circulation of the things vastly exceeds the total of delinquents. We know, too, something about the typical (if there is such a thing) emotional development of children in our culture. However close the theoretical identification of sadism and masochism, their overt manifestations are generally two diametrically-opposed things. And in the child mind, as we know it in general, the masochistic impulses tend to predominate, and to strengthen as the child grows older—so much so that mental or psychic masochism is now a generally accepted concept, and one held by some students to be basic to all neurosis. One need grant only its wide prevalence, however, to suspect that the influence of the horror comics on most children is less sadistic and aggressive than masochistic. This is no more susceptible to proof than Wertham's thesis that the comics are responsible for delinquency; but it can be as well supported by the evidence from neurosis as his theory can by the evidence from misbehavior. This would suggest that the horror comics are more likely to promote (not cause) neurosis than delinquency, and that their general effect is more likely to be found in the manifest content of nightmares and in heightened anxiety than in crime.

It should be stated here—as an emphatic aside to the argument—that most psychiatrists would be as glad to get rid, somehow, of the revolting horror comics as would Dr. Wertham be. A random sampling of three recent issues of three different "comics" reveals startling four-color covers showing a man reduced to homuncular size being hunted by a domestic cat, a scantily-dressed blonde kneeling before a gigantic Negro who is about to decapitate her and add her head to a collection of decaying specimens, and a group at a crossroads at midnight about to drive a stake through a vampire's heart. These three charming publications depict 26 violent

deaths, and have short stories of four more. They concern, among other choice items, werewolves, vampires and ordinary rape, murder and suicide. A man is eaten alive in his bathtub by fish; another beheads his brother, and ornaments a racing car radiator with the brother's head.

As another aside, these stomach-turning things are sold freely and openly and enjoy second class mailing privileges, while serious works may be barred from the mails altogether. This stresses one of the problems met in dealing with undesirable publications. No scientific group could approve action which does not keep as far away from censorship as it possibly can; even the conviction that the comics are at the root of the present juvenile delinquency problem does not lead Dr. Wertham to seek censorship—if one understands him aright—he seems to want police action to see that "horror comics" are sold only to adults. Such moves as the New York State law prohibiting "tie-in" sales, whereby objectionable comics are forced on retail newsdealers, also lend encouragement to the belief that effective action short of censorship can be taken—and it plainly should be.

For this digression from the general subject of delinquency, one might perhaps apologize. But it is impossible to discuss delinquency without discussing the allegations which are most prominently before the public at present—that comic books are an important cause of it. It is impossible to register disagreement with that view without expressing one's own disapproval of the comics. And it is impossible to express disapproval of the comics without registering disapproval of the censorship proposals which, in one way or another, are usually suggested as the best way to dispose of the comics.

But if the comics are not causes of delinquency, what role do they play? One answer is: They may determine some expressions of it. In the past, the racketeer-bigshots set a pattern for delinquents of their day. Before them, were the juveniles who aped moving picture crime; the drugstore "cowboys" who went from copying the manners of the old Wild West to street-corner criminality; the young rowdies who hung around such horrible places as poolrooms and bowling alleys, impressionable youth who learned from their more than rough-and-ready elders in the days when the lower fringes of pugilism merged imperceptibly with petty crime. Unstable young morons with itchy trigger fingers once thought they

were John Dillinger; 50 years before, the masked, two-gun model was Jesse James.

Would-be master-minders of crime have been cut in the pattern of Sax Rohmer's Fu Manchu, Conan Doyle's Professor Moriarity, Dickens' Fagin. There were restless times when youths longed to be heroes like Teach and Blackbeard and much-calumniated Robert Kidd—who, like Sir Andrew Barton of the "three jolly robbers of old Scotland," became the hero of ballads for many generations of men who went down to the sea in ships.

The form of delinquency has always been influenced by the available pattern. Robin Hood was likely more of a rebel than a robber; but the exploits of his merry men must have been the pattern for delinquencies of English boys until gunpowder broke the cloth-yard arrow.

For the last eighty years or so, the underworld characters of Paris have named themselves for the fierce Indian tribe of Apaches. But the pattern of their juvenile and adult delinquencies alike has been less like the real Apache than like that of that flamboyant and typically Gallic character, Louis-Dominique Bourguignon, called Cartouche, and also nicknamed *L'Enfant,* the plague of Paris in the early eighteenth century. Born to a good family, reputed schoolfellow of Voltaire, Cartouche demonstrated his talents for crime early; picturesque, ruthless, personally daring, he defied the police publicly; flaunted alike his startling misdeeds and his exploits with women; devised senseless crimes, each more sensational than its predecessor, for the pure love of the spectacular; organized a disciplined and officered underworld army which may have numbered 3,000 men; and was at once the terror and the idol of the populace. He was still in his twenties when he was finally caught and broken on the wheel. It does not seem fanciful to suspect that the career of this colorful gentleman, who may well have been the most spectacular criminal of recorded time, has influenced the pattern of Parisian delinquency in the two and a half centuries since; and it would be interesting to know whether Gaston Leroux's fictional revival of the Cartouche tale in *The Double Life* some fifty years ago helped keep the pattern alive. But be it noted that what Cartouche inspired was not two centuries of delinquency but a pattern in which delinquency expressed itself. Cartouche, a genuine juvenile delinquent himself if there ever was one, needed no pattern; he very likely designed his own.

One can readily suppose that juvenile misbehavior has followed, now one popular pattern, now another, as far back as the records go; and this discourse aims to say that one can arrive at nothing useful with incredible speed, if one investigates delinquency according to its pattern. Patterns may differ from Egypt of the Pharaohs, Paris of Louis XV and London of Charles Dickens' time to the comic book motif of today; but there is sound psychiatric reason to suspect that underneath them all, the fundamental causes are pretty much the same. The unconscious of mankind, a great deal of field research now indicates, is not widely different in San Francisco, Moscow and Tokyo, or elsewhere between Greenland's icy mountains and India's coral strand; but the conscious may express itself in terms as various as are English, Russian and Japanese, or Eskimo and Urdu. The scientist who wants to know why men behave as they do, starts—or should start—with man's common unconscious factors. The scientist who wants to know the why's of delinquency must start similarly, the generality of other scientific workers might well maintain, with study of the common factors underlying its various expressions. Some of those factors, most psychiatrists would hold, are unconscious; others are matters of social organization and social psychology and can be investigated readily by conventional methods. Since inquiry into unconscious factors is difficult to do and difficult to evaluate—and is perhaps best suited, at the present stage anyway, for individual investigations and individual treatment—even a psychiatric discussion might well open with the weighing of more accessible material.

All the psychiatric work of recent years, and much of the sociological, points to certain common and easily recognizable factors behind juvenile delinquency in general. What the sociologist so loosely—and so regrettably—refers to as "broken homes" represents a number of things to which the psychiatrist refers loosely—and also regrettably—as "rejection," "deprivation of parental love," "childhood traumata" and the like. Psychiatry has approached greater exactitude by way of further compartmentalizing the sociological classifications. It is a process by which the image under the microscope is enlarged until more of its component parts are visible, but the light is far too diffuse for anything like a clear view. One can, however, derive from the great body of work of the social and psychological sciences of the last generation some idea

of the soil on which juvenile delinquency grows and some idea of the elements by which it is nourished.

The picture, as the vast majority of students see it, is one of nothing so simple as "comic books." The answers to genuine, human, emotional questions are invariably complex; the quest to make them simple is futile, pitiful and endless. One can turn to the Old Testament prophets of disaster to find over-simplified examples, single delinquencies of the Children of Israel—singled out from many, and held responsible for everything from the division of the kingdom to the captivity beside the waters of Babylon. It should not stretch anybody's memory to recall the excitement a few years before last (or was it the year before that?) over the discovery that marijuana was responsible for an alarming and unprecedented increase in delinquency. All survivors of the Noble Experiment can remember when the hip pocket flask at high school dances was the principal—almost the sole—delinquency cause. Not too long before, it was the cigarette in the hands of the same age-group (not only did the "coffin-nail" yellow the fingers and shorten the life-span; it often brought about drug addiction, and it led to serious misconduct, for it invariably "weakened the will"). And shortly before, the root of all juvenile evil was in the Nick Carter stories and their like, in the dime-novel detective or Wild West tale.

It should not be necessary to proclaim (but it probably is) that these statements are not endorsements of the healthful effects of comic books, marijuana, hip flasks, or dime novels. They are not even to be construed as a television advertisement for cigarettes because they soothe the nerves, are good for the throat, or taste so good. None of these things, it should be made emphatically plain, are here recommended as good for youth, or even harmless to youth. What is urged here is simply that these various deleterious things be viewed with a sense of proportion and in light of scientific knowledge that they are all symptomatic, not etiologic—a standpoint which sets up a fine target for free spear-throwing by all zealots.

One basic factor in the etiology of delinquency, most psychiatrists who are not too greatly absorbed by one or another surface facet of the problem would probably agree, is the child's feeling of emotional or physical insecurity or deprivation, or lack of understanding and love. A child with this burden may somehow develop

normally, or he may cringe before a hostile world or strike back at it with forbidden activities—and in either of these latter cases, the bad man of the Wild West or Captain Kidd or the werewolves of the horror comics may play a part.

But the chief enemy, the director of the forces of evil, the power behind anti-self or antisocial manifestations, remains in the child's emotional make-up, not in the legendary crime nor in the cartoon algolagnia that colors the result. But neither this primary cause nor possible measures to remove it are prominently discussed when the problem of juvenile delinquency is made a public issue today. Emphasis is generally on the manifestations or on possible repressive procedures. A newspaper publishes a series of horrifyingly-illustrated articles of gang terrorism in numerous New York City schools. Demands to punish parents for the misdeeds of their children become so widespread that the federal Children's Bureau calls a Washington conference of specialists in the social sciences to consider whether such action is practical or desirable. The thirty-first annual conference of the American Orthopsychiatric Association in March 1954 opens with a discussion of the "breakdown" of the family as a cause of crime. New York City's superintendent of schools tells a committee of the City Council that more teachers are needed if delinquency is to be fought successfully; the president of the city's board of education remarks in a radio program that the school situation, "broken homes," and the aftermath of war must share responsibility for delinquency, while in some instances, "the church is not doing its job." A United States Senate subcommittee on juvenile delinquency is told by the writer, Albert Deutsch, that psychiatrists needed to treat delinquents are in short supply because of demand by wealthy patients, and that what is needed in the delinquency problem in general is less blaming of parents and more research.

The New York State Department of Mental Hygiene contributes to the discussion a note by Assistant Commissioner Robert C. Hunt, M. D., that there is a growing recognition that delinquency has its roots in mental abnormality and mental defect, "What used to be considered bad boys, are now sick boys." And the recognition of illness and defect in delinquents has increased the burden of the children's units at Kings Park and Rockland state hospitals, Dr. Hunt remarks, and is creating increasing problems in the state schools. Dr. Fritz Redl, chief of the children's division, National

Institute of Mental Health, speaks for another governmental agency on a somewhat different point; addressing a conference of parents and educators, he calls for parental conduct that is neither totalitarian nor totally permissive toward children, but which intervenes by prohibiting when necessary and, at the same time, encourages "intelligent rebellion"—a program with serious implications in the way of possible preventive measures in both home and school.

All this is a very impressive amount of thunder and lightning, and it seems to be recognized generally as such. "The Inquiring Fotographer" of the *New York Daily News* bases two queries on juvenile delinquency in his series of not too profound or enlightened questionings of the public at large: "Does a suspended sentence discourage youthful wrongdoing?" and "How were you delinquent when you were young?" A point of interest is that one of the "fotographed" interviewees who replied in the negative to the first question thought that judges were too lenient today, although the suspended sentence was all right years ago when "juvenile delinquency didn't cause mass hysteria." The answers of interest to the second query were from a man whose delinquency as a boy consisted of getting even with a delinquent adult, who had torn down his wireless antenna, by throwing stones through all the adult's windows; and from a man who, as a boy in Holland, had dug a tunnel into a dike to see if the water really would come in. These two performances by presently respectable citizens may, perhaps, serve as introduction to Dr. Sophia M. Robison, who has been working and teaching for 30 years in the field of delinquency and related problems, and who contends that most juvenile delinquency is simply part of the process of growing up—"growing pains" as a *New York Times* headline summarizes it. Dr. Robison, who has five children of her own and 11 grandchildren, and is now retiring as professor of social work research at the New York School of Social Work, divides her delinquents into three groups: healthy children whose poorly channeled overactivity gets them into trouble; children undergoing difficulties in emotional relationships with their parents; and children with serious emotional illness. Dr. Robison does not consider the delinquency of this seriously ill group to be growing pains; and she laments that we do not sort these children out properly so they can be treated. She is quoted as saying ". . . we treat all the children who come to the courts the

same—we call them delinquent." (One might do well to excuse one's self from the probably-resulting argument.)

It is Dr. Robison's third group, the seriously ill who become more and more maladjusted, more and more anti-social, more and more criminal, who feed the fires of hysteria over juvenile delinquency. Consider the self-confessed (or, maybe, braggart) four-time murderer and rapist-killer of a 14-year-old New York City schoolgirl. At 27, he has the background one so often finds among adults who have graduated from a course of juvenile crime, deprivation in childhood, a drunken father who died when the boy was seven, a drunken and neglectful mother, a commitment to Children's Village at 13 for stealing money and a watch from a club locker, and a term in a "correctional" institution for defective delinquents after pleading guilty to burglary charges at the age of 18. This youth was noted in a probation bureau report as having been diagnosed psychiatrically as a psychopathic personality without psychosis, of dull normal intelligence, and as having such serious neurotic conflicts that "it would take quite some time to straighten them out." Let us not quibble regarding diagnostic categories; the major point here is that he was recognized as belonging to the group Dr. Robison finds in need of attention; and no way was provided to do anything practical about it—supposing anything practical, other than the punishment imposed, could have been done. But it should also be noted that this case is a splendid instance of where not to go view-hallooing off on a vengeful chase of today's horror comics. This boy's first offense was in the pre-comic days of 1940.

Some other directions in which there is no point in leading a mad dash have been mentioned. The Washington conference of specialists to consider "the increasing demand in certain areas to strengthen punitive measures against parents of delinquent children" concluded, most fortunately, that there was no sense in any such thing. Mandatory, inflexible and universally applied sanctions are not effective correctives for parental irresponsibility, the conference held. No psychiatrist familiar with the revenge-on-the-parents element that so frequently enters into juvenile offenses can fail to agree.

Dr. Ernest W. Burgess, addressing the recent Orthopsychiatric Association conference, makes some observations which might warn against following another false trail. "The breakdown of the home," "broken homes," "the vanishing American home," are

terms the psychiatrist has been hearing with some irritation for as long as he has dealt with the delinquency problem. Dr. Burgess, professor emeritus of sociology at the University of Chicago, tells the orthopsychiatric meeting that the American family is not dying, breaking down or otherwise disappearing; it is changing.

The family, one may observe here, has been changing since human life began. It likely was matriarchal at first; it has since been, among numerous other things, patriarchal and matrilocal, patriarchal and patrilocal, matriarchal and polyandric, patriarchal and polygamous, patriarchal and monogamous. The weight has shifted this way and that as social, economic and religious conditions have changed. We have been in a period of particularly rapid change for the last century; the railroad, the factory, the growth of cities, the automobile and the moving picture were all, at one time or another, going to break up the American family. Some of them did change it and are still changing it. We now seem to be approaching stabilization on the level of a more democratic, companionable and less authoritarian family than we have ever seen, with more co-operation and fewer demands between parents, and between parents and children, than there have been in the past. If this is so, we are still in a period of transition, and transition periods are always difficult. But, if we are indeed in such a period, which may have started a hundred years ago, it also follows that change is change, not death or dissolution. Any student of the literature of ethnology or any experienced anthropological field worker can testify that there are almost innumerable types of families in which children have been brought up successfully, happily, without intolerable stress or frustration, and without conduct regarded as delinquent. For emotional reasons, it is a disturbing realization, but it is, nevertheless, true that our familial organization is not necessarily fixed, immutable, or the best that can be achieved in the best of worlds. A trend toward increased co-operation, greater mutual respect, more democratic behavior, in the family suggests that we are moving toward improvement, not deterioration.

But assuming that there is change and that change is comparatively rapid and that its unsettling effects can influence even slightly our delinquency problem, what—practically—can we do about it? To begin: We can reinforce our efforts, both in the changing family and in the changing outer world, to build the security, the acceptance and the growth to maturity that forestall de-

linquent behavior. And one may well refer again here to Dr. Stevenson's discussion of the problem.

Dr. Stevenson conceives delinquency as deriving from two general sources: the social and economic inequities of our culture which the mental hygiene worker can only point to with recommendations that experts in other fields work these problems out; and the emotional causes that must be primarily of psychiatric concern. Dr. Stevenson would cope with some of these by a prevention program of improved child guidance services in the schools, more clinics for children and parents with specific problems, better general mental health education for parents, renewed attempts to adapt our schools and train our teachers so they will meet better the emotional needs of our children. He suggests also a program for the better handling of delinquents once delinquency is a fact—with greater provisions for determining the delinquent's emotional illness, with increased psychiatric staffs in correctional institutions, with improved juvenile court organization, with special training in emotional problems for persons dealing with delinquency, police, lawyers and clergymen among others. This, of course, is not presented as a panacea, or even as an adequate statement of the problem; it is one specialist's outline of some of the principal questions involved in it.

It should not be inappropriate here to add a few more specific suggestions. In the greatly-to-be-welcomed process of reducing parental tyranny, there is too often an accompanying reduction in the familial discipline which is necessary for the child's own sound emotional development and necessary for his protection. In the business of making the school a happier place for children (which has been discussed at length elsewhere by this journal), there is too often a loss of discipline to a point below the minimum necessary for teaching or general good order. And there has been what is often referred to inaccurately as growing disregard and disrespect for religion; one might suggest that it would be nearer the mark to hold that, in lessening their invocations of fear and terror, many of the clergy have failed to build correspondingly, respect for the moral principles, the tolerance, understanding and charity which should take their place.

Mental hygiene efforts could be very appropriately directed to building in the home the respect and affection for the parents which should replace old-fashioned totalitarianism. They could

be well directed, and the need is urgent here, toward restoring as much of school authority as is necessary for successful teaching and general good order. They could be well directed toward emphasizing or developing the moral qualities which the churches teach and which the individual must possess if he is to act maturely on his own instead of immaturely as the pawn of a once-feared authority.

An encouraging social consciousness of the problems of our children and an increasing social conscience in regard to them is plainly developing; a bad social conscience is plainly an element in present hysterical excitement over delinquency. One of the last and most cherished concerns of the great pioneer psychoanalyst Paul Federn was with an unpublished work in which he sought to define what he felt ought to be a legally-guaranteed bill of rights for children. More recently, a book has actually been published in which Philander Priestly Claxton, educator and school and college administrator, presents his own views of the rights society should secure to the young. And one may hope others will now take active interest. An enlightened psychiatric view might be that in addition to love and acceptance and the various physical necessities for well-being, a child has a right, also, to kindly guidance and to the aid of a firm but humane discipline that will help him later to cope with the frustrations and injustices and imperfections that he must meet in a much too human world.

Such guidance and discipline do not call for a return to the rod, but rather for the sympathetic understanding and development of the qualities of tolerance and control that a child needs in dealing with his peers and his elders and that the youthful adult must have in a grown-up world.

It might be a fruitful project if something like a tenth of the professional attention now devoted to problem children were turned to the study of the upbringing of a group of reasonably normal, reasonably intelligent children. Society had standards for the maintenance and the smooth operation of the more patriarchal family of our grandparents' day. It needs standards adapted to our own day now, and we preachers of mental hygiene might well do something toward providing them. A good place to begin our study of the problem might be the attempt to find out why the majority of our children do *not* become delinquent, and to identify the forces that lead them to socially-acceptable behavior.

The great, comprehensive effort called for if we are to cope scientifically with the juvenile delinquency problem will be a long, painfully difficult job, sure to be productive of mistakes and disappointments, promising no quick results, offering no panacea. It is much simpler to go screaming off to "Punish delinquent parents!" Or, "Pass new laws to hold the family together!" Or, "Burn the so-and-so comic books!" (Even if art, literature and scientific research also go eventually to feed the flames!)

BOOK REVIEWS

The Psychiatrist and the Law. By WINFRED OVERHOLSER, M. D., Sc.D. X and 147 pages. Cloth. Harcourt, Brace. New York. 1953. Price $3.50.

Dr. Overholser is the first recipient of the Isaac Ray award which was established in 1952 for the most worthy contribution to the improvement of the relations of law and psychiatry.

In his "Isaac Ray Award Book," he considers four main aspects of forensic psychiatry. The first section is a summary and covers the present position of psychiatry; the second pleads for a closer rapprochement of law and medicine. "The Mental Patient and the Hospital" discusses the differing state laws governing the mentally ill; and the final section is devoted to the role of the psychiatrist in the courtroom.

Successive writers in this field will have no small task to match Dr. Overholser's interest, enthusiasm and thought-provoking material.

Bodily Changes in Pain, Hunger, Fear, and Rage. By WALTER B. CANNON, M. D. 404 pages with 40 figures. Cloth. Charles T. Branford Co. Boston. 1953. Price $5.00.

This text is a reprint of Cannon's second, 1929, edition. It is partly based on many previously published papers from the physiological laboratory of the Harvard Medical School.

In the first half of the book are some of Cannon's original kymographs. There is factual evidence that emotion stimulates release of "adrenin," causes hyperglycemia, counteracts fatigue, hastens blood coagulation, increases the number of red blood cells.

In the last half of the book, the physiological findings are interpreted and correlated with emotions and reactions of fear and flight, rage and fight. Cannon states that strong emotions are mediated through the sympathetic system's interfering with the cranio-sacral division of the autonomic; for example interfering with digestion. He reasons that during the sex act the sympathetic system may be co-ordinated with the sacral autonomic nerves. He discusses the similarity and interrelation of strong emotions of pain, fear, and rage. These reactions may be the "stock in trade" of the self-preservation instinct.

Cannon's researches are always to be respected. They are physiological. They are fundamental to understanding the pathological stress syndrome of Gelye.

Prescription for Rebellion. By ROBERT LINDNER, Ph.D. 305 pages. Cloth. Rinehart. New York. 1952. Price $3.50.

Prescription for Rebellion is an attempt to be "thought provoking" and "revolutionary" in the field of behavior and psychology. "I believe that the science and practice of psychology has fallen upon an evil day, that somewhere it became lost, diverted, and forgetful of its high and significant purpose. I believe that it has come to grief upon the shoals of the regretful hypothesis of adjustment. But I also believe that it can yet be saved." The Billy Graham of psychoanalysis (left of left-wing) continues, "I have already stated the purpose and aim for which the concept of adjustment is employed. It is to obtain dominion over humankind, to exercise power over men, to keep them in a condition of servitude, to stifle thought and bind action. Those who propagate the concept fall into two classes: holders or seekers of power, and dupes who are either unaware of what they are doing or unable to foresee where their advocacy of this fallacious proposal for living is leading them and their fellows. Neither kind can nor should be forgiven, for both are in league to produce Mass Man, the creature whose flat features already can be recognized among the faces of men."

Writing without one shred of modesty but an abundance of pedantry, Lindner waves the banner of a much-abused psychology. "How is psychology actually employed today? By politicians to propagandize for power, to enslave the peoples in error, to arouse passions and lusts, to awe, hypnotize, and subvert: —by the military to create mindlessness, to regiment and to paralyze individuality, to awaken atavistic appetites for hate and slaughter: —by business to nourish greed and to tempt with trifles, to lull discontent, to drain creative energies, and to promote mechanized efficiency: —by the clergy to engender submission and bind protest, to instill fear, to cultivate primitive taboos: —by parents to subdue and to dominate, to enforce obedience and inhibit instinct." Lindner—realist or rabble-rouser? The reviewer fears this accumulation of not too much sense does not make for wisdom.

Children in Play Therapy. A Key to Understanding Normal and Disturbed Emotions. By CLARK E. MOUSTAKAS, Ph.D. IX and 218 pages. Cloth. McGraw-Hill. New York. 1953. Price $4.50.

Written by a psychotherapist of the Merrill-Palmer school, this book vividly portrays the experiences of well-adjusted and disturbed children in play therapy. The writer is highly successful in clarifying purposes and techniques, basing his illustrations on tape-recorded case sessions. His book should have wide appeal to both professional and parent groups.

The Life and Work of Sigmund Freud. Vol. 1. The Formative Years and the Great Discoveries, 1856-1900. By ERNEST JONES, M. D. 428 pages including index. Cloth. Basic Books. New York. 1953. Price $6.75.

It would be difficult to select a better biographer of any man than Ernest Jones is of Freud. The first volume of what will undoubtedly be the definitive life of Freud covers Freud's early years from his boyhood through his medical studies and early practice, to the development of his dream interpretation and the theories on which the science of psychoanalysis has been based.

Dr. Jones is qualified as a long-time personal friend, a pupil, a master of the scientific discipline which Freud founded, and a distinguished writer in his own right, to depict Freud with authority. He also seems to have achieved, insofar as anybody could be expected to achieve it, a very high degree of objectivity. This first volume not only contains material of the greatest scientific importance, but it is written in an easy style and is fascinating reading.

Freud would not have approved of this book, the author believes. He had already disclosed his personal life to a painful degree and he felt that he and his family were entitled to privacy. But generalizations, misinterpretations and downright falsehoods about Freud's life brought about a change in the family attitude and amply justify the present portrayal.

The man Jones pictures is intensely human as well as of tremendous intellectual stature. The author, for instance, in discussing Freud's pioneer work in the medical use of cocaine, points out that the young enthusiast's distribution of it to friends and colleagues was such that: "In short, looked at from the vantage of our present knowledge, he was rapidly becoming a public menace." The author frankly discusses Freud's life in the 1890's as a period during which he was suffering from "a very considerable psychoneurosis" which he relieved by self-analysis. He takes up his professional and personal relationships without the display of idolatry that has characterized some others of Freud's pupils.

This is an unforgettable picture of Freud as a person, a young husband and father, an enthusiastic young scientist and a pioneer in perhaps the most difficult path ever trodden by the medical profession. It is hardly necessary to say that no professional library, or no personal library of anybody concerned with psychiatry or psychoanalysis, should be without it.

The Origins of Psycho-Analysis. By SIGMUND FREUD. 486 pages including index. Cloth. Basic Books. New York. 1954. Price $6.75.

Freud's letters to Wilhelm Fliess, his closest friend among professional contemporaries of his early middle age, are important source material for the history of psychoanalysis. Edited by Marie Bonaparte, Anna Freud

and Ernst Kris, they cover incidents of Freud's life and the development of Freud's thinking in the early years of psychoanalysis. The correspondence ended when the two men's ideas finally developed in directions that were totally incompatible. They quit writing, and there were some public recriminations.

Freud derived, as he repeatedly stated, important ideas from Fliess. He wrote much to him, not only about personal, family and professional incidents, but often about his developing psychoanalytic theories. In addition to the letters proper, this volume includes an essay, entitled here "Project for a Scientific Psychology," of which Freud completed three of four apparently projected parts and sent the manuscript for Fliess' evaluation.

This volume is, of course, a requirement for every psychoanalytic library. It is in addition of value to all who are interested in Freud as a man, and interested in the development of psychoanalysis as a science.

The Psychoanalytic Study of the Child. Volume VI. Ruth Eissler, Anna Freud, Edward Glover, Phyllis Greenacre, Willie Hoffer, Heinz Hartman, Edith B. Jackson, Ernst Kris, Lawrence S. Kubie, Bertram D. Lewin, Rudolf Loewenstein, Marian C. Putnam, Rene A. Spitz, editors. 398 pages including bibliography. Cloth. International Universities Press. New York. 1951. Price $7.50.

The volumes of this series are primarily for children's analysts. They will, however, also be found well worth while exploring by psychiatrists, pediatricians, children's psychologists and psychiatric social workers.

Volume VI contains a group of presentations given at a conference sponsored by the Austin Riggs Foundation in 1950 upon the occasion of Anna Freud's visit to the United States.

The range of the papers is wide: The reader will find highly theoretical papers as well as clinical reports. The topics covered are: problems of child development, problems of masturbation, early childhood, latency, adolescence.

To this reviewer, Anna Freud's "Observations on Child Development" and her report, in collaboration with Sophie Dann, "An Experiment in Group Upbringing," are outstanding examples of clarity of expression and organization, which, however, some of the other papers lack.

His Name Was Death. By FREDERIC BROWN. 191 pages. Cloth. Dutton. New York. 1954. Price $2.75.

Here is another suspense novel by one of our superior mystery story writers. The criminal doings of a psychopath are portrayed with plausibility by the author in a story full of tension, and with a surprise climax calculated to suit the most avid "who-done-it" reader. One of the writer's best to date.

The Impact of Science on Society. By BERTRAND RUSSELL. 114 pages. Cloth. Simon and Schuster. New York. 1953. Price $3.00.

Lord Russell, as one of the most influential and accomplished philosophers of our age, has written a most stimulating book on a subject which each day becomes of greater concern to all. As we daily are informed of new and deadlier weapons of destruction devised by the applied sciences, *Quo Vadis* becomes a crucial question.

The author is sensitive to the potentials of war and peace, freedom and despotism, famine and plenty which lie in the searches of the scientist. He also is aware that scientists are not always free to pursue their findings and use their abilities to constructive, enlightening purposes. Therefore a greater sharing of responsibility with the community as a whole is necessary. While science has today at its disposal the means to create a world of unimaginable and unbelievable fullness for humanity, world conditions of distrust, greed and false conflict have kept peoples apart and deprived the scientist of support and aid in fulfilling his promise.

He discusses the relationship of science with tradition, with war and with standards of values. He attempts to analyze scientific technique in democracy and in what he calls oligarchy. Through it all, the reader must conclude that the fate of science lies with us as social scientists and as individuals who must take certain responsibilities for the atmosphere in which scientists must operate and for the uses to which we put their efforts.

Woman's Change of Life. By ABNER I. WEISMAN, M. D. X and 134 pages. Cloth. Renbayles House. New York. 1951. Price $2.50.

Weisman has an easy-going, understandable approach to a natural phenomenon which every woman will experience in her mature years. A variety of symptoms, and related topics such as artificial menopause, change-of-life babies and marriage after menopause are discussed.

Of added interest are the medieval woodcuts which were discovered by Prof. James V. Ricci of New York.

The Sword from the Rock. By G. R. LEVY. 236 pages including index. Cloth. Grove Press. New York. 1954. Price $7.00.

The Sword from the Rock is a discussion of the epic and the development of the hero from Gilgamesh, Hittite ritual, the Ramayana and Mahabharata, through Homer to the *Morte d'Arthur*. There is a tremendous amount of erudition and a great deal of psychological insight in the author's treatment of the epic as man's interpretation of life or as his endless quest.

Seduction of the Innocent. By FREDERIC WERTHAM, M. D. 397 pages. Cloth. Rinehart. New York. 1954. Price $4.00.

As is widely known, *Seduction of the Innocent* is Dr. Wertham's blistering and documented indictment of the modern "comic" book for its destructive effect on children. It has attracted nationwide interest and newspaper headlines.

Dr. Wertham is a widely-known authority in the field of forensic psychiatry and has had close professional acquaintance with delinquency as director of the Court of General Sessions Psychiatric Clinic in New York City. The psychiatrist is unlikely to quarrel with the factual material of the book. He will, however, be less likely to endorse its implications and conclusions. Wertham, like Don John of Austria, has taken weapons from the wall and set forth on the crusade. He smites the enemy in all directions, but the reader who is mindful of his own scientific balance will question whether he has identified the enemy properly. This reviewer, for example, while sharing to the full Wertham's abhorrence for the crime and sex comic, questions whether this sort of thing is the cause of the juvenile delinquencies which Wertham finds performed by comic book readers. By the nature of the material, it is probably impossible to have adequate controls for such a delinquency series. It is also impossible to judge how much comic-book reading is the cause of delinquency, how much is its expression, and how much has nothing whatever to do with it.

The reviewer thinks this book has considerable educational and factual value but would suggest that lay readers in particular be cautioned against the hysterical reactions which follow a wild jump to conclusions, and that professionals approach it with due professional restraint.

Mussolini. By PAOLO MONELLI. 304 pages including index. Cloth. Vanguard. New York. 1954. Price $4.00.

This is a general account of Mussolini as a personality rather than a revelation of his "intimate life" as the subtitle would indicate. The author apparently did have access to material not generally available about Il Duce, and he has used it to create a readable and interesting, if somewhat superficial, account of this history-making demagogue. One learns, for instance, that Mussolini was inclined to substitute perfume for baths, and that his promiscuous love-making had all the finesse of a rooster's in a barnyard. There are also a few notes of interest on what seems to have been the progress of his general paresis. In default of better material, the social scientist may find this book an interesting and not unimportant outline.

My Fight to Conquer Multiple Sclerosis. By HINTON D. JONEZ, M. D. 227 pages. Cloth. Messner. New York. 1952. Price $3.50.

Is multiple sclerosis an allergic reaction? This is a question many neurologists would like to have answered.

My Fight to Conquer Multiple Sclerosis tells the story of the St. Joseph Hospital Multiple Sclerosis Clinic, Tacoma, Washington state. Stimulated by a statement made by Dr. Bayard Horton of the Mayo Clinic, Dr. Jonez began treating multiple sclerosis with histamine. Although his methods of treatment were called "Jonez's folly" he continued to experiment with the treatment, combated the many prejudices expressed by members of the medical profession, but finally, with the help and determination of Sister Celine Magdeline of the St. Joseph Hospital, Dr. Jonez developed a clinic wherein—it is reported—many unfortunate persons have received help.

Dr. Jonez explained to his patients ". . . how controlling multiple sclerosis was something like building a table. Histamine, allergy management, curare, and physiotherapy formed the four solid legs of the table. Psychotherapy formed the top of the table. We could help the patient build the foundation, but putting the top on the table was largely up to him. . . ." To the medical profession ". . . I said repeatedly that we never had claimed that any of these therapeutic practices actually *cured* multiple sclerosis."

Dr. Jonez' story is a very stimulating one. His book is well written. He gives many brief case histories, describes his methods of using histamine, his use of d-tubocurarine to relieve muscle spasm, then the use of physiotherapy and finally the great need of psychotherapy and an atmosphere of hopefulness.

It is hoped that Dr. Jonez' story, which was, apparently, written for the lay reader, will not create false hopes. His "trial and error" methods make common sense but, as yet, have not been proved scientifically. Physicians should read Dr. Jonez' article "Management of Multiple Sclerosis" in the May 1952, issue of *Postgraduate Medicine*. In this article he briefly, but specifically, describes his treatment methods.

Hypnosis in Modern Medicine. Jerome M. Schneck, M. D., editor. 323 323 pages. Charles C. Thomas. Springfield, Ill. 1953. Price $7.50.

Here is an attempt to integrate the use of hynotherapy and hypnoanalysis with *all* the medical fields including dentistry, obstetrics, anesthesiology, etc. Hypnoanalysis is described in conjunction with psychosomatic disease in all fields of medicine, and hypnotherapy is discussed in association with the pain and discomfort allied with so many medical and surgical procedures.

The Psychology of the Criminal Act and Punishment. By GREGORY ZILBOORG, M. D. 141 pages including index. Cloth. Harcourt, Brace. New York. 1954. Price $3.50.

This is the second series of Isaac Ray Award Lectures delivered at Yale University schools of law and of medicine—Winfred Overholser delivered the first. Dr. Zilboorg's lectures cover an analysis of the differing viewpoints of law and psychology on the responsibility and treatment of the mentally disordered criminal. His exposition differs from many similar psychiatric discussions chiefly in being more keenly thought out and better phrased. The lawyer and the psychiatrist, he points out, approach the criminal from diametrically opposite backgrounds. The lawyer is trained to identify with justice, not with the man called before the bar of justice. The physician in general and the psychiatrist in particular are trained to identify with the individual human being. The two points of view are irreconcilable.

Dr. Zilboorg suggests, perhaps with tongue in cheek, that we might do well to see that young law students had more human contact with criminals, as medical students have human contact with sick people. He wonders, for instance, if it would not have a good effect if such young students were to visit jails and prisons, serve as prison guards, witness executions, take case histories from prisoners. The law, he remarks, has "old, established scales of legal values, and all the psychiatrist is asked to do is to offer precise definitions and accurate tests in support or refutation of the claims of the criminal law. It is a matter of genuine knowledge that such tests do not exist, and I doubt whether they ever will."

Cases in Court. By SIR PATRICK HASTINGS. 342 pages. Cloth. British Book Centre. New York. 1949. Price $2.95.

Cases in Court presents the account of 21 cases brought before a court of law. They range from slander and libel to murder, and present the author as the advocate for both guilty and innocent parties, and sometimes as advocate for neither side but as an interested observer. As a psychological study of human beings on trial, the book misses a tremendous opportunity. It is the author's belief that the advocate should not see his client before the case comes to trial and it must thus necessarily follow, that Sir Patrick can know little about the complex factors which make up the personalities of his clients or of the subtle motivations behind the actions which have brought them to a court of law.

Rather the book presents repetitions of the trials with their various legal ramifications and leaves the reader with the feeling of seeing only the cold exteriors of stories which undoubtedly contain strong inner emotions.

Autobiography of a Schizophrenic Girl. Reality Lost and Regained, with Analytic Interpretation. By MARGUERITE SECHEHAYE. Translated by Grace Rubin-Rabson. 159 pages. Cloth. Grune & Stratton. New York. 1951. Price $3.50.

Madame Sechehaye, a graduate of the University of Geneva, Switzerland, psychologist and psychoanalyst, is well known on the continent for her treatment and interpretation of schizophrenia.

The first part of the present book is the autobiography of Renée, who recounted it to her therapist shortly after her recovery. It begins with her first feelings of unreality. The second part contains the interpretation of illness and recovery. "Once starting with an unsatisfied basic need, Renée could make no adequate adaptation to reality. Approaching adulthood, a too-demanding environmental complexity drove her back to a lower infantile level of development [p. 142]."

Renée's ego collapsed, involving a regression to the fetal level. In the interpretive words of the author-analyst, this was the method of treatment: "Renée reached the adult normal level, climbing and ascending the road toward the simultaneous conquest of her ego and of reality, possible only through desubjectivization and decentralization of the ego." Some of Piaget's descriptions of stages in a child's construction of reality are woven into the analytic interpretation. Renée, suffering from a particularly early and severe form of dementia præcox, recovered without surgery or shock treatment. Her account will be of use and interest to anyone engaged in therapy.

Genetic Neurology. Paul Weiss, editor. 239 pages. Cloth. The University of Chicago Press. Chicago. 1950. Price $5.00.

In March 1949 the first meeting of the International Conference on the Development, Growth and Regeneration of the Nervous System was held. From it (all written *after* the conference) came this symposium of essays written by some of the world's foremost authorities in embryology, neurology, psychology, pathology, biochemistry, histology and other related fields. Weiss contributes the introduction while such men as Hyden, Hooker, Stefanelli, Piatt, Flexner, Young, Sunderland and Schmitt, are seen throughout the work.

Design for Aggression. By PETER DE MENDELSSOHN. 259 pages. Cloth. Harper. New York. 1947. Price $3.50.

This is a collection of documentary proofs, partly submitted at the Nuremberg trials, of Hitler's specific orders for successive attacks, from the *Anschluss,* to the Russian campaign. Since the deductions rest completely on captured authentic material, no doubt is possible. This is a valuable collection of more than historical interest.

Kierkegaard's Philosophy of Religion. By REIDAR THOMTE. 228 pages. Cloth. Princeton University Press. Princeton, N. J. 1948. Price $3.80.

This book presents a concise picture of Kierkegaard's religious philosophy, growing from an acid reaction to the materialistic diabetic of Hegel, tracing it step by step in a competent analysis. A considerable portion of the analysis is devoted to Kierkegaard's inquiry into Christian ethics, the nature of the Christian life, and the evolution of Christendom, which reveals the plan and goal of the major portion of his writing: "to revise the conception of what it means to be a Christian." The author has attempted to relate the various stages in the evolution of Kierkegaard's thought to his personal life. The style is lucid and smoothly flowing. Anyone who has attempted to follow Kierkegaard's tortuous mysticism in the original sources should find this book a welcome aid in unraveling his philosophic thought.

A History of Philosophical Systems. Virgilius Ferm, editor. 609 pages. Cloth. Philosophical Library. New York. 1950. Price $6.00.

The editor has coordinated the efforts of 41 authorities to present a history of philosophical thinking in Asia, Europe, and America through centuries of recorded thought. The summaries of the many schools are succinct and are, for the most part, easy to read. It is perhaps of greatest value as a source book somewhat in the abridged tradition of a decade ago when condensations were held to be the only salable form of material otherwise difficult to digest.

Like much academic philosophy, this book fails to relate the formal philosophies adequately to their historical settings. Only passing mention is made of the cultural, political and economic factors from which each philosophy arose. While the student may need to be acquainted with the important "names" in such a history, one gets here the false impression that philosophy is the ivory realm of a few great thinkers.

Embattled Maiden. By GIRAUD CHESTER. 296 pages. Cloth. Putnam's. New York. 1951. Price $4.00.

Embattled Maiden, the biography of Anna E. Dickinson, often referred to as the Joan of Arc of the Civil War, is, for the most part, undeniably dull. There is little here to make the heroine seem real flesh and blood, although there is chapter upon chapter telling of her speaking engagements and the issues she discussed. Surprisingly enough, the last section of the book, which deals with Miss Dickinson's psychosis, is well done. Her behavior is described in detail, and there are samples of her writing while she was a patient in a mental hospital. For the professional, this section makes the book worth while.

The Psychiatrist, His Training and Development. By J. C. WHITEHORN, M. D., et al. 214 pages. Cloth. American Psychiatric Association. Washington, D. C. 1953. Price $2.50.

This report of the 1952 conference on psychiatric education presents the historical background of psychiatric residency training. A formulation of ideal, and of actual, training situations follows.

The conference should be commended for its handling of psychodynamics. No specific agreement as to a psychodynamic formulation could be reached, but a general statement, with amendments by members who differed, was offered. The problem of how this material is to be presented—by didactic lectures, personal analysis, supervised use of psychotherapy, etc.—is discussed. The conferees' view on the necessity for personal analysis is to be noted. "It is not necessary to be psychoanalyzed in order to develop competence as a psychiatrist, including competence in psychotherapy and psychodynamics. It is highly desirable that some persons should receive a personal analysis." The relationship of psychiatry for children to training needs is well presented.

Training centers and the programs offered; special fields in psychiatry such as industrial, forensic and military; and personal traits desired of residents are discussed.

This volume is presented in a clear fashion despite the obvious complexity of the subject and despite lack of agreement among psychiatric educators. A provocative report!

Psychotic and Neurotic Illnesses in Twins. By ELLIOT SLATER. 385 pages. Paper. Medical Research Council Special Reports Series. H. M. Stationary Office. London. 1953. Price $4.75.

This report on nearly 300 twins suffering from psychiatric illnesses can be well reviewed by the author's own conclusion: "The report confirms previous views of genetical factors. We found that 76 per cent of the uniovular twins of schizophrenics had schizophrenic illnesses . . . Within concordant uniovular pairs there were often wide differences in the severity of the illness and in outcome. These facts suggest that genetical causes provide a potentiality for schizophrenia, perhaps an essential one, though environmental factors play a substantial role. . . . There is a striking contrast between the psychoses . . . and psychopathic and neurotic states. In the latter, uniovular pairs were less frequently concordant, and some of the binovular pairs developed very similar troubles despite big differences in intelligence and personality. . . . However, personality is even of greater importance in these conditions than in the psychoses. . . . The basic make-up of the personality is largely determined by heredity."

Beyond This Place. By A. J. Cronin. 316 pages. Cloth. Little, Brown. Boston. 1950. (Re-issued 1953.) Price $3.75.

Buying one of Dr. Cronin's books is like buying your regular brand of cigarette. His work is rounded, firmed and fully packed. The only question about this one is: Is it packed with what you expect in the regular brand? The answer is that it is Cronin all right, but one of those new additives is thrown in; and this new ingredient may well be corn. The good doctor seems to have developed an exaggerated sense of melodrama, which he hardly needs and which adds nothing to his stature.

Beyond This Place has the drama, the suspense, the sweep and warm human feeling that mark his work; but it is trite, contrived and a little over-sensational for such a writer. The writing is still first rate but the situations would do credit to television where all the ends simply must be tied up at all costs.

General Psychology. By Douglas H. Fryer, Edwin R. Henry and Charles P. Sparks. 300 pages including index. Paper. Barnes & Noble. New York. 1954. Price $1.50.

This is an outline textbook for a course of college credit in general psychology. Its authors are authoritative, and excellent reference material to standard texts is listed. The study of personality which is, of course, the primary interest of psychiatry in psychology, is touched upon briefly but adequately and various dynamic schools are treated with as little bias as one could well ask.

This book should be a useful manual for any teacher of general psychology, and should be an exceedingly useful reference book for school of nursing and other professional-educational libraries.

Women Needn't Worry. The Menopause. By Lena Levine, M. D., and Beka Doherty. VIII and 188 pages. Cloth. Random House. New York. 1952. Price $2.75.

Facts about the menopause are plainly and adequately presented by a gynecologist and a medical journalist. Both somatic changes and emotional adjustments are clearly discussed.

This little book is readable and offers sound guidance and information.

The Blind Bull. By George Williams. 469 pages. Cloth. Abelard Press. New York. 1952. Price $3.50.

In an army hospital on Saipan, Major Clem Sweeney—after a hard childhood and a successful civilian career—fights a battle for life, or perhaps in his case, a battle for death. Reviewing his life from his hospital bed, it seems to him that everything good which has happened to him has had an evil counterpart. *The Blind Bull* is the story of his weighing the good and bad for a choice between life and death.

Respiratory Diseases and Allergy. By JOSEF S. SMUL, M. D. 80 pages. Cloth. Medical Library. New York. 1953. Price $2.75.

This is a comprehensive coverage of respiratory diseases in three sections: "Allergic Diseases of the Respiratory System," "Infectious Diseases of the Respiratory System," and, "Neoplastic Diseases of the Respiratory System."

Under allergic diseases, Dr. Smul includes 22, some of which are often considered infectious. He suggests the treatment of these diseases should be carried out in one general manner and states that this is "a new method of approach."

Under infectious diseases, he includes such diseases as acute tonsilitis, diphtheria, pertussis and influenza. He gives the definition, etiology, pathology, symptoms, diagnosis and recommended treatment of each. Under neoplastic diseases he covers the malignancies of the respiratory system in the same fashion.

Patient's Doing Fine. By DAVID M. DORIN. 122 pages. Cloth. Vantage Press. New York. 1951. Price $2.50.

In this short book Mr. Dorin succeeds in allaying some of the major fears of the new general hospital patient. He discusses surgery, the meanings of a few of the more common medical terms and the means behind some medical and surgical ends. Also included is a chapter on the principles of medical ethics.

Mr. Dorin has been a general hospital patient and is at present a hospital director and consultant so he writes with both practical authority and theoretical background.

The Lovely Season. By VIRGINIA EVANS. 312 pages. Cloth. Appleton Century. New York. 1952. Price $3.50.

The Lovely Season is a fantastically amateurish novel on epilepsy. Besides naïveté, the book excels in development of a basic error—a disease may be objectively tragic, and still not serve as an adequate subject for a novel. The ABC of a novel consists of inner development of character on the basis of inner conflicts. One cannot substitute external events or events unrelated to the personality structure.

The Night the Old Nostalgia Burned Down. By FRANK SULLIVAN. 248 pages. Cloth. Little, Brown. Boston. 1948. Price $3.00.

Frank Sullivan has long been contributing humorous and acute personality sketches to the *New Yorker* and other publications. *The Night the Old Nostalgia Burned Down* is a collection for any adult's reading. The three little essays based on the cliché expert should be recommended to all adult writers in addition.

The Shadow of a Dream. By CHARLOTTE HALDANE. 287 pages. Cloth. Roy Publishers. New York. 1953. Price $2.50.

This is a novel, friendly toward extrasensory perception. The author, being a journalist, confuses the elements of technique of a novel with a magazine piece. A novel should describe the developments of character and its psychological implication. What can be described when the dubious gift of "second sight" is static and inexplicable?

Prisoner of Grace. By JOYCE CARY. 301 pages. Cloth. Harper. New York. 1952. Price $3.00.

This British author achieved with his previous novels some acclaim, even enthusiastic approval, by reviewers. The present volume is an excruciatingly boring affair about a half-silly girl who attaches herself to an even more silly officer, to be married off to a hypocritical politician who "swallows" even two illegitimate children. Nothing is explained in the book, nothing motivated beyond the level of the silliest rationalization.

The Merry Heart. By S. FELIX MENDELSOHN. 260 pages. Cloth. Bookman Associates. New York. 1951. Price $3.00.

If the humor here is just a little quaint it is not the fault of the author; it is because the humor is pure. The familiar characters of Jewish legend, their foibles and wry philosophies are captured here. It is a good volume to have around for random reading and to trace origins of jokes like: "Who was that lady I seen you with last night?"

The Early Frost. By CLARE JAYNES. 248 pages. Cloth. Random House. New York. 1952. Price $3.00.

A routine book, capitalizing on pity for the children of broken homes, this tale is written without the slightest understanding that reality is but the raw material. How the child elaborates it—corrects or perpetuates the pattern—is overlooked.

Toward Manhood. By HERMAN N. BUNDESEN, M. D. 175 pages. Cloth. Lippincott. Philadelphia. 1951. Price $2.95.

The aim and purpose of this book is to discuss sex and sex problems that arise in adolescent boys. The subject matter is discussed honestly, frankly and clearly. This is clearly one of the better books in this area.

Street Music. By THEODORA KEOGH. 287 pages. Cloth. Farrar, Straus and Young. New York. 1951. Price $3.00.

Here is an attempt at describing juvenile delinquency in a novel. The author succeeds in bringing to life a girl of 11, and fails in presenting an adult longing for his delinquent past. Perhaps the author is in the wrong field and should be writing children's books.

The Szondi Test. A Popular Introduction for Psychologists, Educators, Theologists, Physicians and Social Workers. By Prof. Dr. E. SCHNEIDER, Basel. 80 pages including bibliography, illustrations, tables and diagrams. Paper. Hans Huber. Bern and Stuttgart. Distributors for the U. S. and Canada: Grune & Stratton. 1952. Price Fr. 9.50.

This small book is intended to be a popular introduction to the fundamentals, technic and evaluation of the Szondi Test.

The Szondi Test is a comparatively new psychological method of examination, applying projective technic. It is based on Szondi's fundamental doctrine of the "analysis of destiny," by which Szondi tries to prove that latent hereditary functions are active in the selection of sexual companions, of friends, of one's profession, even of diseases and type of death by an individual. On the basis of this genetic doctrine, Szondi developed his own theory of libidinous urges, governing the course of life and directing the development of the personality. This "*Triebtheorie*" of Szondi is the theoretical foundation for the new diagnostic test.

The test procedure is as follows: Six sets of eight photographic pictures each are presented successively to the individual who is examined. Each set contains a typical photograph of a homosexual, of a sadist, of an epileptic, of a hysteric, of a catatonic, of a paranoid, of a manic, and of a depressed person. The test subject is requested to select the pictures he likes best and dislikes most. Reaction time and other secondary responses of the test individual are registered in symbols and evaluated according to an elaborate scheme. A new terminology is introduced for classification which cannot be translated easily into English terms.

The author of this introduction expects that the Szondi Test will be of value: first, for consultation on choice of profession or trade and for examination of the reasons for professional failure; second, for premarital advice and corresponding examination in marital difficulties; and, third, in consultation regarding adjustment to school and environment. The author admits that more research will be necessary to prove the reliability and the range of the test.

Without expressing a personal opinion of the value and possibilities of the test, this reviewer wants to point out that it probably will not be an easy task for anyone, not familiar—thoroughly and critically—with Szondi's theories and doctrines to utilize this procedure in psychological examination. It may be added that terminology and style are not helpful.

Scirocco. By ROMUALDO ROMANO. 184 pages. Cloth. Farrar, Straus and Young. New York. 1951. Price $2.75.

Scirocco is a novel about boredom and a few psychopathic personalities in a small place in Sicily. There is all-pervading doom and gloom. But depression for depression's sake is not literature.

Childhood Problems and the Teacher. By CHARLOTTE BUHLER, FAITH SMITTER and SYBIL RICHARDSON. With a chapter on remedial work by Franklyn Bradshaw. 372 pages with bibliography and index. Illustrated. Cloth. Holt. New York. 1952. Price $3.75.

Charlotte Buhler, who presently holds the position of assistant clinical professor of psychiatry at the Univerity of Southern California School of Medicine, formerly was professor of psychology at the University of Vienna. She is well known for many texts and papers, particularly on developmental psychology. Lately she has published presentations on therapy and the Rorschach technique.

The present book, on which psychologists and teachers have collaborated, attempts three things, as stated in its preface: to give the teacher an understanding of the dynamics of behavior problems to determine by means of case examples what the teacher may achieve, and to describe the type of problem with which the teacher needs specialized assistance.

The illustrative case studies include children from many cultural backgrounds from infancy through the age of 17. Forty-one drawings by children are reproduced in black and white along with their clinical interpretations. *Childhood Problems and the Teacher* fills a real need. More books like it are needed to bridge the gap between clinicians and educators.

Specialized Techniques in Psychotherapy. Gustav Bychowski, M. D., and J. Louise Despert, M. D., editors. XII and 371 pages. Cloth. Basic Books. New York. 1952. Price $5.00.

One may well turn to this work as a good reference book in the field of psychotherapeutic practices. It is the culmination of seven years of work conducted by the Psychiatric Forum Group. It contains 17 different problems of therapy, presented by 19 leading specialists in psychiatry, psychoanalysis and psychology. The book details the concepts, theories, research and clinical data of such specialized techniques as hypnoanalysis, narcotherapy and art therapy. A large section is devoted to psychological disorders of children, with contributions by Beata Rank, Bela Mittelmann and J. Louise Despert.

The common structure of this book is based on Freudian psychoanalysis. The specialized techniques described are modifications necessitated by present-day development of theoretical knowledge and clinical experience.

The wide variety of topics limits the individual writers' discussions, so that one gets something of a "success" bias, but, despite this, the case material is well presented.

Delinquents in the Making: Paths to Prevention. By SHELDON and ELEANOR GLUECK. 214 pages. Cloth. Harper. New York. 1952. Price $3.00.

This concise volume is a simplified version of the findings of research into persistent delinquency published in 1950 (New York Commonwealth Fund) under the title *Unraveling Delinquency*. Researches by the Glueck team into causes, treatment and prevention of crime have been in process since 1940, and they are still continuing.

Five hundred delinquents are matched in this study against 500 non-delinquents of similar age, general intelligence, racial derivation and residence in underprivileged urban neighborhoods. On the basis of statistically tabulated comparison, the Gluecks are trying to "isolate" the most important causative factors of delinquent behavior.

The authors emphasize, throughout, the dynamic interplay of a great many factors. In trying to distinguish the delinquents from the non-delinquents, the following traits were found to be characteristic of delinquents: physically, in tending to be of mesomorphic constitution, which means muscular, solid; temperamentally, in being restless, energetic, aggressive, destructive; in attitude, being hostile, defiant, non-submissive intellectually, in tending to direct and concrete, rather than symbolic, abstract, intellectual expression; and socioculturally, in having been reared to a far greater extent than non-delinquents in homes of little understanding, affection and stability.

As "paths" to prevention the Gluecks recommend a great variety of measures, which they focus on the characteristics of the delinquent himself; family life; school; and employment of leisure time.

The testing of children, early and periodically (through Rorschach and psychiatric interview) to detect malformation of emotional development while the "twig can still be bent" is recommended.

The Somatic Therapeutic Proceedings in Psychiatry. A Text- and Handbook. By Dr. MAX MÜLLER, professor for psychiatry at the University of Bern. Volume I: *Insulin Therapy*. 295 pages including bibliography of 30 pages, author index, reference index, 20 tables and 4 illustrations. Cloth. George Thieme Verlag. Stuttgart. 1952. Price DM 36.—.

This first volume of a well-planned and well-organized text and handbook in German on somatic therapeutic procedures in psychiatry is an excellent example of—and an addition to—the classical textbooks of the pre-Nazi period. Its organization, its completeness, its thoroughness, its presentation, the careful bibliography and arrangement of the indices will make it a most useful, reliable reference book. Author and publisher have done an excellent job.

The Leaven of Love. By IZETTE DE FOREST. 206 pages including index. Cloth. Harper. New York. 1954. Price $3.50.

Mrs. de Forest not only discusses Ferenczi's philosophical and ardently practiced clinical principle that love is the great instrument of redemption and healing in psychoanalysis, but she illustrates it from her own 25 years of analytic practice. She gives a clear and apparently objective account of Ferenczi's differences with Freud and his reasons for them. An oversimplification would present the Freudian and Ferenczian orientations as the passive and active participation of the therapist in analysis.

The account is of considerable historic interest and importance, particularly in reference to Ferenczi's relationship to Freud where friendship was preserved in spite of sharp theoretical and practical differences.

Mrs. de Forest writes simply and includes a glossary for the benefit of the lay reader. Her work, however, in theory and in notes on methods and incidents of practice, will be of principal use to the active practitioner.

How Love Grows in Marriage. By L. F. WOOD. 183 and VI pages. Cloth. Macmillan. 1950. Price $2.50.

Dr. L. F. Wood is a Baptist minister who has been secretary of the Commission on Marriage and the Home of the Federal Council of Churches since 1932. His books on marriage have reached a circulation of almost a half-million.

This little book, based on counseling with many men and women, shows considerable insight and is easy, interesting reading. Many short case histories, show the most common marital problems. This work is about as practical as any book can be, and is to be highly recommended—for its simple prose, as well as for a guide.

Cell 2455 Death Row. By CARYL CHESSMAN. 361 pages. Cloth. Prentice-Hall. New York. 1954. Price $3.95.

Cell 2455 Death Row is the autobiography of a man who writes after a life of violence while awaiting execution at San Quentin. Chessman's extremely high IQ and his literary ability have been well advertised, and this book lives up to its reputation on all counts. It is something worth reading by everybody who is interested in criminology or psychopathy, and that should mean not only the professional but all who have a social conscience among us.

Strangers and Afraid. By THOMAS STERLING. 275 pages. Cloth. Simon and Schuster. New York. 1952. Price $3.50.

This is a boring, pretentious novel about a functionary of a humanitarian league, and a colored boy who tells him his troubles. Psychological motivations are not discernible.

Your Hay Fever and What to Do About It. By HENRY SWARTZ, M. D. 175 pages. Cloth. Funk & Wagnalls. New York. 1951. Price $2.75.

This book, written primarily for hay fever sufferers, is at times, extremely technical and, at others, almost too simple.

Beginning with the early medical history of hay fever, Dr. Swartz discusses both the symptoms and treatment of the three distinct types. He gives a list of rules for hay fever sufferers and also discusses fallacious ideas about the disease.

This is a worth-while little volume for its specific public.

The Long Home. By NEIL S. BOARDMAN. 338 pages. Cloth. Harper. New York. 1948. Price $3.00.

In this novel about the illusions and disillusions of adolescents and post-adolescents of the early depression years in the Middle West, the author tries—unsuccessfully—to recapture the "going off at a tanget" spirit (sexually, spiritually, politically). To illustrate his style: "Spring broke . . . Get busy O daughters of sin; get busy adulterers and fornicators; get busy impotent ones, write your lewd verses; husbands, turn to your wives and paw their unyielding bodies; lovers, awaken and kiss; there is little enough time in this lost land that freezes your belly in winter and melts it to lard in July. . . ."

The Discipline of Well-Adjusted Children. By GRACE LANGDON and IRVING W. STOUT. 244 pages. Cloth. John Day. New York. 1952. Price $3.75.

This book should be welcome reading for parents, teachers, and just about anyone working with children. The authors point out the changing trends, in popular and professional thinking, about discipline over the past 75 years. Without pressing their own views, they are able to convey, by the statements of parents, how the everyday problems of the average child can be handled.

The Great Enterprise. Relating Ourselves to Our World. By H. A. OVERSTREET, Ph. D. 332 pages. Cloth. Norton. New York. 1952. Price $3.50.

The author of the *Mature Mind* undertakes here to explore more fully the effect upon the individual of the larger world in which we live. If one can assume that enough people have matured since his first book was read, then one can expect a good reception for the later work. Unhappily the people who should read this probably will not.

Morbus Alzheimer and Morbus Pick. By TORSTEN SJÖGREN, HAKON SJÖGREN and AKE G. H. LINDGREN. Translated by Donald Burton. 152 pages including extensive bibliography and references, 11 pages of figures, many tables, diagrams and pedigrees. Acta Psychiatrica et Neurologica Scandinavica, Supplementum 82. Ejnar Munksgaard, Nørregade 6, Copenhagen. 1952. Price 25 Swedish Crowns.

This monograph deals exhaustively with the presenile psychoses. It contains a genetic study, a clinical analysis and a patho-anatomical classification of Alzheimer's and Pick's diseases. The genetic and clinical part of the work contains a wealth of material for study in detail.

Eighteen cases of each type were examined histo-pathologically. The essential differences between the two diseases as derived from the material presented are: 1. relative diffuse cerebral atrophy in connection with morbus Alzheimer, circumscribed in morbus Pick; 2. regular changes in the basal ganglia in connection with morbus Alzheimer, found in only one case of morbus Pick; 3. fibrillar changes and argentophil plaques regularly and in great numbers in connection with morbus Alzheimer, never in morbus Pick; 4, no ballooned cells in the cases of morbus Alzheimer, such cells found regularly in connection with morbus Pick.

The monograph contains a complete bibliography on the subject and a number of excellent illustrations of pathology.

Psychotherapy. Life and Work of Great Physicians. By Prof. J. H. SCHULTZ, Dr. med. 180 pages. Cloth. Hippokrates Verlag, Marquardt & Cie. Stuttgart. 1952. Price DM 14.50.

The aim of this book by a well-known Berlin psychiatrist is not quite clear. It is a rather disorganized and arbitrary history of psychological medicine from Mesmer to our times, but it describes almost exclusively the European, or even more the German, scene. It is an incoherent compilation of quotations and is neither informative nor stimulating. The presentation is unsatisfactory, even from the publishing point of view: The typography makes the reading definitely no pleasure. This work will not attract the American reader.

Psychosis and Civilization. By H. GOLDHANGER and A. MARSHALL. 126 pages. Cloth. Free Press. Glencoe, Ill. 1953. Price $4.00.

This is a statistical report to the effect that there has been no increase of the frequency of the psychoses during the past 100 years. The authors estimate that the chances of becoming psychotic are one in 20 by the age of 45, and about one in 10 by the age of 65. Neuroses are not included in the study.

Narcotics, U. S. A. Paul B. Weston, editor. XIX and 319 pages including preface, glossary, appendix, bibliography and index. Cloth. Greenberg. New York. 1952. Price $4.00.

This book fills a gap felt by many social agencies, physicians, lawyers, educators and others who have to deal on their respective levels with narcotics and their users. Though not entirely homogeneous in quality of the different chapters—as cannot be expected in a compendious compilation—it gives enough and sufficiently competent information and an adequate bibliography on all problems of the narcotic menace. This work can definitely be considered a very useful reference book. Especially informative are chapters XI (the illicit traffic in drugs), chapter XII (drugs and crime), XIII (control and suppression), XIV (the law today), XIX (a plan for tomorrow) and the reprints of the "uniform narcotic drug acts" of the states of New York and of Illinois.

The American Soldier. Studies in Social Psychology in World War II. Vol. I, Adjustment During Army Life. XII and 599 pages with tables and charts. Vol. II, Combat and Its Aftermath. 675 pages with index to Vols. I and II. Vol. III, Experiments in Mass Communication. X and 345 pages, including preface and index. Social Science Research Council, editorial sponsor. Cloth. Princeton University Press. Princeton. 1949. Price, Vols. I and II, $13.50 (separately $7.50 each); Vol. III, $5.00.

This is a unique work, compiled from first-hand material by an outstanding group of excellent authorities. It is hardly a work for detailed critical —or even thorough descriptive—reviewing here but it can be said that it is a tremendous compilation of information in sociology and social psychology.

Persons interested in mass psychology and mass communication will find this work basic.

How to Be a Better Parent. By Barney Katz. 258 pages. Cloth. Ronald Press. New York. 1953. Price $3.00.

Whether one will be a better parent after reading Dr. Katz' tome is a matter for conjecture. If the good doctor is writing for the profession, the profession should know it already; and, if the message is for the parent, perhaps a few pictures would help. It isn't that the theories are wrong, but that the method of presentation is not right. If the average parent took the time to try to understand this book, there wouldn't be any time for the children.

There is, however, a nice chapter on "The Child's Struggle for Happiness," which is constructive and revealing and makes a couple of good points—that is, provided anyone is still with Dr. Katz up to page 93.

Encyclopedia of Aberrations. A Psychiatric Handbook. Edward Podolsky, M. D., editor. 550 pages. Cloth. Philosophical Library. New York. 1953. Price $10.00.

This book claims to be a psychiatric handbook but falls well below the mark. It is rather, a combination of mediocre definitions of some psychiatric terms, and reprints, from journals, of various aspects of psychopathology. Some of the articles and studies reprinted are good, and they are the best features of the book. However, a major omission here is that dates of original publications of these articles are omitted.

The title of the book is poor and vague, besides being too inclusive. The jacket design simply adds to the vagueness. The book is poorly bound and the price is too high. This book is not recommended as a suitable handbook. It is far inferior to the scholarly *Psychiatric Dictionary* by Hinsie and Shatzky.

Man in Society. By George Simpson. 89 pages. Paper. Doubleday. New York. 1954. Price 95 cents.

This is the first in a series of short studies for beginners in sociology. Initially, this paper deals with the similarities and differences and the relations of physical science and social science. Then the subdivisions of social science and their interrelations are discussed. Sociology, social psychology and individual psychology are compared and contrasted. A brief but adequate résumé of Freud and his followers' work is included. The application of the scientific method to sociology, the fields in sociology and value in social science complete the picture.

The approach is a historic and philosophic one. The result does not seem suitable as a basic text in teaching but more as reference material. The author is reasonably objective. The book's application to psychiatry is limited.

And Dream of Evil. By Tedd Thomey. 287 pages. Cloth. Abelard-Schuman. New York. 1954. Price $2.50.

If a man can carry around a slot machine, make love to an amazing number of beautiful blondes, kill indiscriminately and have a fairly healthy arm and conscience—then this story is plausible. Otherwise. . . .

Three Men. By Jean Evans. 297 pages. Cloth. Knopf. New York. 1954. Price $3.75.

Three Men is made up of the case studies of three social misfits. It is starkly lucid and complete. In it, Johnny Rocco, William Miller, and Martin Beardson are seen, felt, lived with and understood. It is masterful, finished portrayal.

Vocational Services for Psychiatric Clinic Patients. By THOMAS A. C. RENNIE, M. D., and MARY F. BOZEMAN. 100 pages. Cloth. Commonwealth Fund. Harvard University Press. Cambridge. 1952. Price $1.25.

The other day a president of one of our great universities expressed belief that scholars lay too great emphasis on narrow projects. This came to the mind of this reviewer while reading the present book. As a descriptive study about the vocational services to outpatients of six psychiatric clinics—five in New York City and one, as a sample of a small town clinic, in Jackson, Mich.—it is a well and conscientiously carried-out job. But the authors do not go far beyond a routine description, and proof of the obvious, as on p. 19: "The study showed that the social worker played a key role in the discovery of vocational problems and in their resolution through attention to and assistance with social aspects of the patients' lives and through referral to vocational agencies."

This reviewer is of the opinion that statistical data are rather meaningless when concerned with the obvious need for vocational guidance in people whose emotional disturbances affected their working capacities. He does not feel helped by learning that "of 93 women with vocational problems 64, or 68.8 per cent had difficulty in applying their skills or maintaining employment in a presumably satisfactory vocational field. Less than half of the 171 men presenting problems 83, or 48.5 per cent, indicated that this was their difficulty" (pp. 15-16). A professional worker in the field however will feel that the whole material could have been presented more interestingly in a paper of 15 pages.

The list of the vocational agencies which is included in the study will be useful for reference, and the index is well done.

Analyzing and Predicting Juvenile Delinquency with the MMPI. Starke R. Hathaway and Elio D. Monachesi, editors. 153 pages including index. Cloth. University of Minnesota Press. Minneapolis. 1953. Price $3.50.

Seven carefully designed studies on the use of the Minnesota Multiphasic Personality Inventory in analyzing and predicting juvenile delinquency comprise the major contents of this volume, with perhaps the most significant, one by the editors which involved a longitudinal study of 4,048 ninth-graders. In contrast to most studies, which are based on data collected after the individual becomes delinquent, the Hathaway-Monachesi surveys begin with children below the age where the sharp rise in delinquency occurs and follow up with a later investigation to determine who becomes delinquent. The summary result is that the MMPI seems to provide useful categories into which a substantial number of delinquent adolescents will fall.

The Juvenile Offender. By CLYDE B. VEDDER, Ph.D. 510 pages. Cloth. Doubleday. New York. 1954. Price $6.00.

Here is a sizable volume recording contemporary thought. It is organized around several themes supported by source readings. The material is rather repetitive, often requiring more interest than the average reader can muster.

The discussion of etiology tends to be superficial. Individual consideration for the delinquent is admirably emphasized, rather than "an eye for an eye" justice. Much is a sad commentary on the lack of progress made in this field, but such projects as group therapy and a new philosophy for juvenile court judges, probation officers and reform school practices offer hope if generally accepted.

The factual material, variety of experimental studies and social orientation may serve to make this book of use to college students in sociology, etc.; but it has limited features to offer the psychiatrist.

The Cliff's Edge. By MARIE HACKETT. 245 pages. Cloth. McGraw-Hill. New York. Toronto. London. 1954. Price $3.50.

Marie Hackett's husband had been home from the war for some time when he developed a paranoid schizophrenic condition. She and her husband work to save their family while he is a patient at a psychiatric hospital for veterans.

The story is human and honest. There are no punches pulled and those reading it cannot help but understand better the problems of the mentally ill and their families. For the psychiatrist, it is a clear outline of what his patients leave behind. For the layman, it is the basis for understanding. For the ones the mentally ill leave behind, it is a ray of hope.

This is a wonderful companion book for the fine story written by Mrs. Hackett's husband, *The Cardboard Giants*. It was written while he was confined and arranged after he was discharged.

Handwriting and the Emotions. By MALFORD W. THEWLIS, M. D., and ISABELLE CLARK SWEZY. 264 pages. Cloth. American Graphological Society, Inc. New York. 1954. Price $8.00.

This is a survey of graphology with the emphasis on its use as a diagnostic and indicative tool, comparable to, and, the authors feel, equal to the Rorschach and the Cornell Service Index. The authors feel that graphological evidence, as discussed here, and the science of handwriting analysis should be compatible with more commonly accepted evidence. Problems of emotions, mental illness, vocational choice and other considerations of graphology are covered in explicit detail. A good deal of space is used for illustrative specimens.

Psychiatric Aspects of Juvenile Delinquency. A Study Prepared on Behalf of the World Health Organization as a Contribution to the United Nations Programme for the Prevention of Crime and Treatment of Offenders. By LUCIEN BOVET, M. D., Consultant in Mental Health, W. H. O., Médecin-chef de l'Office médico-pédagogique rattaché au Département de Justice et Police de l'État de Vaud, Lausanne, Switzerland. 92 pages including bibliography. Paper. World Health Organization. Palais des Nations. Geneva. 1951. Price $1.00.

No single book gives such an excellent and complete survey of the urgent problem of juvenile delinquency in concentrated and yet readable form as Dr. Bovet's work which is modestly called "a study." While juvenile delinquency is defined somewhat vaguely as a "bio-psycho-social phenomenon," this work seems to impress on the student of this world-wide problem its complexity and the fact that one "cannot afford to neglect any one of the three terms of this expression." Here is implied, in the author's opinion, the necessity of teamwork by the educator, the sociologist, the geneticist, the physician, the magistrate and the psychologist—in which the psychiatrist can become the most useful link, uniting all workers interested in juvenile delinquency, because the psychiatrist has acquired sufficient understanding to attempt to reconcile all viewpoints. Above all, the psychiatrist may be able to help formulate practical approaches to each worker's daily activities.

There is interesting presentation of the various points of view of different countries as to the concept of juvenile delinquency, and, even more, as to the approach to prophylaxis and treatment. There is not a single factor of the "bio-psycho-social phenomenon" left undiscussed or without support by quotations and bibliography from the world literature. The careful study of this fundamental work cannot be too highly recommended.

Drives, Affects, Behavior. Rudolph M. Loewenstein, editor. 399 pages. Cloth. International Universities Press. New York. 1953. Price $7.50.

This book is comprised of essays in honor of Marie Bonaparte. A wide variety of papers of various lengths is presented on the theoretical, clinical and applied aspects of psychoanalysis. Most of the authors are recognized in the field and the variety and stimulating nature as well as the excellence of their presentations make this book a useful addition to psychoanalytic literature. This book is highly recommended for its theoretical contributions by such authors as Hartmann, Kris, Loewenstein, Jacobson, Schur, Odier and DeSaussure; for clinical contributions by Lampl-DeGroot, Greenaire, Lewin, Knight, and others; and for papers on application of analytic theory to literary, social and anthropological problems by such workers as Anna Freud, Eissler and Róheim.

The Interpersonal Theory of Psychiatry. By HARRY STACK SULLIVAN, M. D. 393 pages. Cloth. Norton. New York. 1953. Price $5.00.

This book is the first volume to be based on the unpublished lectures of Harry Stack Sullivan. As the editors state, "The present book has been limited mainly to a series of lectures which Sullivan gave in the Washington School of Psychiatry in the winter of 1946-1947, since this series represents the last complete statement which Sullivan made of his conception of psychiatry." Thus, this is the first comprehensive and systematic presentation of Sullivan's theoretical position and, as such, is a highly important work to an understanding of one of the leading psychiatric figures of our day. The book outlines Sullivan's basic ideas; gives a detailed account of his developmental approach, beginning with the dynamisms and interpersonal relations of infancy; includes a section where the author discusses various clinical problems; has a final chapter on the social significance of psychiatry.

The book, as it is composed of lectures to students, is informal and interesting, with many examples from clinical experience, and it contains many useful and illuminating insights.

The Girl in Poison Cottage. By RICHARD H. HOFFMAN, M. D., and JIM BISHOP. 166 pages. Paper. Fawcett (Gold Medal Books). New York. 1953. Price 25 cents.

Here are some of the unpolished facts leading up to the trial of Frances Creighton and Everett Appelgate for the arsenic murder of Ada Appelgate —matters accepted as facts by Martin Littleton, district attorney at the Creighton-Appelgate trial.

The book is well written and concise, but its interest lies in the authors' disagreement. Richard H. Hoffman, the psychiatrist who helped solve the case and is a co-author, feels to this day that Appelgate was guilty and suffered a just punishment. Jim Bishop, the other co-author, feels that Appelgate was innocent of murder but was rather convicted and electrocuted because of his rape of a 15-year-old girl. Circumstantial evidence alone was presented.

Wives and Lovers. By MARGARET MILLAR. 308 pages. Cloth. Random House. New York. 1954. Price $3.00.

This psychological novel is heralded as Mrs. Millar's first major attempt to deal with the lives and loves of "ordinary" middle class people in contemporary society. With little plot, the author has made the everyday affairs of a small group of individuals into as absorbing a tale as any of her suspenseful mystery stories. Her book has both literary excellence and psychological plausibility.

Child Psychology. By LEIGH PECK. 519 pages. Cloth. Heath. Boston. 1953. Price $5.25.

For the student of elementary psychology, Professor Peck's book discusses basic tenets of child psychology.

Beginning with the prenatal development of a child, the book gives a comprehensive explanation of the subject of heredity, and the role it plays and its interaction with environment. Broadly breaking down a life span into babyhood (0-2 years), preschool (2-5), older child (6-12), adolescent (12-18) and mature individual (18+), the book discusses the primary problems which arise at each of these age levels.

A large part of the book is devoted to the evaluation of mental development; with a parallel section on emotional and social adjustment. Throughout the book the author emphasizes the fact that most of the children he is discussing are average children; and he, therefore, devotes a section to those with personality disorders and behavior problems.

Professor Peck avoids the psychoanalytic theory of child behavior and sticks to a purely primary level. He covers a great variety of subject matter, however, and his book should prove useful as an introductory text.

Across the Street from the Courthouse. By MICHAEL A. MUSMANNO. 411 pages including index. Cloth. Dorrance. Philadelphia. 1954. Price $4.00.

Justice Musmanno of the Supreme Court of Pennsylvania was a presiding judge at the International War Crimes Trials in Nuremberg. A man who sat in justice on the Nazis is an equal enemy of the Communist conspiracy. *Across the Street from the Courthouse* is where he found a Pennsylvania Communist headquarters. This is an account, generally temperate, with much documentation, of Communism as he knows it and as he and others have been finding it in the United States. It is a book well worth the attention of any social scientist.

Men: The Variety and Meaning of Their Sexual Experience. A. M. Kritch, editor. 319 pages (3-page glossary and 3-page index). Paper. Dell Publishing Company, Incorporated. New York. 1954. Price 35 cents.

This is the companion volume to *Women: The Variety and Meaning of Their Sexual Experience* (and, of course, owes its publication to the Kinsey reports). Like its companion, it is too technical for the average person—for whom it is intended. It contains contributions by Freud, Havelock Ellis, Karl A. Menninger and Kenneth Walker, among others. A pocket book edition of this material—with its newsstand distribution to pornography seekers—is inappropriate.

CONTRIBUTORS TO THIS ISSUE

DONALD L. GERARD, M. D. A former United States Public Health Service research worker in the field of drug addiction, Dr. Gerard is now an attending psychiatrist at Riverside Hospital, a New York City institution for the treatment and rehabilitation of adolescent drug users, and is consultant psychiatrist (associate research psychiatrist) of the New York State Mental Health Commission in its alcohol research program. Graduated from the University of North Carolina in 1943 and the Long Island College of Medicine in 1947, he interned at the New York Polyclinic Medical School and Hospital and later served at Brooklyn (N. Y.) and Worcester (Mass.) state hospitals. He was with the United States Public Health Service from 1951 to 1953, serving—among other assignments—at the addiction research center at Lexington, Ky., and as director of the juvenile addiction project (a field study of the Laboratory for Socio-Environmental Studies of the National Institute for Mental Health) in New York City. Dr. Gerard is particularly interested in research in the overlapping areas of psychiatry and social sciences; and several of his publications reflecting this interest have appeared previously in THE PSYCHIATRIC QUARTERLY.

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World War II. The methedrine investigation which is the subject of his paper in the present issue of THE QUARTERLY was conducted by him and colleagues when he was chief of an army neuropsychiatric center at the William Beaumont Army Hospital in El Paso, Texas, during the Korean war.

Dr. Brussel is a graduate in medicine of the University of Pennsylvania and holds diplomas in both psychiatry and neurology from the American Board of Psychiatry and Neurology. He has held many teaching and consultant posts; he has contributed to psychiatric textbooks and scientific periodicals (including numerous previous contributions to this QUARTERLY) and is editor of psychiatry for Collier's encyclopedia and yearbook. Dr. Brussel is author of numerous medical articles for the laity, an activity he regards as a hobby, and of short stories, poems and crossword puzzles. Other hobbies include organ playing and raising parakeets.

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BENJAMIN MALZBERG, Ph.D. Dr. Malzberg has been director for the last 10 years of the Bureau of Statistics of the New York State Department of Mental Hygiene. A graduate of the College of the City of New York and of the New York School of Social Work, he has A. M. and Ph.D. degrees from Columbia and has also studied sociology at the University of Paris and University College, London. He joined the Department of Men-

tal Hygiene in 1928 after serving for five years as statistician of the New York State Board of Charities. He was senior statistician and assistant director of the Bureau of Statistics until his appointment as director in 1944. He is author or co-author of numerous books and scientific articles on statistical aspects of mental disorder.

RICHARD C. ROBERTIELLO, M. D. Dr. Robertiello is in private practice as a psychiatrist and psychoanalyst in New York City. He is chief psychiatrist at the Long Island Consultation Center, Forest Hills, N. Y., and is attending psychiatrist at the New York Eye and Ear Infirmary. Dr. Robertiello received his B. A. degree from Harvard in 1943 and his M. D. from the College of Physicians and Surgeons, Columbia University, in 1946. He interned at Morrisania City Hospital, New York City, and held psychiatric residencies at Central Islip (N. Y.) State Hospital, the New York State Psychiatric Institute and the New York University-Bellevue Medical Center. He received his psychoanalytic training from the Flower Group at New York Medical College. He is certified in psychiatry by the American Board of Psychiatry and Neurology.

Dr. Robertiello is the author of a number of scientific articles. He is married and has two children. He lists his hobbies as sports, bridge and the theater.

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ROBERT E. PLUNKETT, M. D. Dr. Plunkett is assistant commissioner for tuberculosis control in the New York State Department of Health and is widely known as a consultant on tuberculosis. He has served in that capacity for a number of foreign governments and for other states in this country. He is a diplomate of the American Board of Preventive Medicine and is author or co-author of many papers on tuberculosis control.

HENRY BRILL, M. D. Dr. Brill is assistant commissioner of the New York State Department of Mental Hygiene. A graduate of Yale Medical School in 1932, he has been with the New York State service since that time. He was director of Craig Colony when he was appointed assistant commissioner in 1952. Dr. Brill is a diplomate in both psychiatry and neurology

of the American Board of Psychiatry and Neurology and is a diplomate of the National Board of Medical Examiners. He is author or co-author of scientific papers on various aspects of psychiatry, particularly the organic therapies. He is an associate editor of this QUARTERLY.

ELSE KRIS, M. D. Dr. Kris, a graduate of the medical school of the University of Vienna, studied psychiatry under Wagner-Jauregg and Freud. She trained at Vienna University clinics and later served at the Vienna Children's Infirmary. She has been on the staff of Pilgrim (N. Y.) State Hospital since 1942, has been in charge of electric shock units there since 1943 and has been active in the aftercare program for psychosurgery patients. She has published papers on electric shock therapy and psychosomatic problems.

JOSEPH D. LICHTENBERG, M. D. Born in Baltimore, Dr. Lichtenberg received his A. B. degree from The John Hopkins University in 1944, and his M. D. degree from the University of Maryland Medical School in 1950. After an internship at Lutheran Hospital of Maryland, he worked for two years at Spring Grove State Hospital, Catonsville, Md., and he has served as consultant for Boys' Village Training School, Cheltanham, Md. At present Dr. Lichtenberg is completing his residency at Sheppard and Enoch Pratt Hospital and is a student in the Baltimore Psychoanalytic Institute.

OTTO BILLIG, M. D. Born in 1910 in Vienna, Dr. Billig was graduated in 1937 from the medical school of the University of Vienna. After general and psychiatric experience as a student intern in Vienna, Dr. Billig served for seven years at Highland Hospital (psychiatric unit of Duke) as resident, associate in neuropsychiatry, clinical director and director of the Duke Rehabilitation Clinic, Asheville Division, Asheville, N. C. Since 1948 he has been psychiatrist-in-chief of the outpatient department of the Vanderbilt University Hospital, Nashville, Tenn. He is associate professor of psychiatry at the Vanderbilt University School of Medicine. Dr. Billig is a diplomate of the American Board of Psychiatry and Neurology and is the author of a number of scientific articles on projection techniques, schizophrenia, insulin shock therapy, and cultural aspects of mental disturbances.

ROBERT ADAMS, M. D. Dr. Adams is a graduate of the Vanderbilt University School of Medicine in 1948. He interned at Wesley Memorial Hospital, Chicago, and was a resident from 1949 to 1952 at Vanderbilt University Hospital, Nashville, Tenn. He is an instructor in psychiatry at the Vanderbilt University School of Medicine.

DANIEL C. BROIDA, Ph.D. Dr. Broida is chief clinical psychologist at the Veterans Administration Mental Hygiene Clinic, Rochester, N. Y., and is clinical associate in psychology at the University of Rochester. A graduate of Dartmouth, where he majored in psychology, Dr. Broida took his M. A. and Ph.D. degrees from Syracuse University. He served a psychological internship at New Hampshire State Hospital, later was a Veterans Administration clinical psychologist trainee and from 1951 to 1952 was a staff clinical psychologist at the Veterans Administration Mental Hygiene Clinic in Boston.

Dr. Broida is married and has two children. He is author of several publications on psychological subjects and has engaged previously in research on possible psychodiagnostic indications of suicidal tendencies, the subject of his paper in the present QUARTERLY.

MORRIS J. TISSENBAUM, M. D. Dr. Tissenbaum has been chief neuropsychiatrist and director of the mental hygiene clinic, Brooklyn Regional Office of the Veterans Administration since 1947. Born in New York City, he attended school there and received his B. S. from New York University. He studied medicine at the University of Paris, where he received his M. D. in 1936. He interned at Jacksonville, Fla., and held residencies in neurology and psychiatry at the Boston City Hospital and the Institute of Human Relations, Yale School of Medicine.

Dr. Tissenbaum served as staff psychiatrist at Rhode Island State Hospital and Norwich (Conn.) State Hospital, as well as with various Veterans Administration hospitals. During World War II, he was a major in the army and clinical director of the neuropsychiatric division of the Valley Forge Army General Hospital. He is a member of local and national psychiatric and neurological societies, including fellowship in the American Psychiatric Association. He is adjunct attending neuropsychiatrist at the Montefiore Hospital where he also instructs in neurology (for the College of Physicians and Surgeons, Columbia University).

GARFIELD TOURNEY, M. D. Born in Quincy, Ill., in 1927, Dr. Tourney received his M. D. degree from the University of Illinois, College of Medicine in 1948. After a rotating internship at University Hospitals, Iowa City, Iowa, in 1949, he began his residency in psychiatry at the State University of Iowa Psychopathic Hospital. This was completed in June 1952, at which time he received an M. S. degree in psychiatry. From July 1952 to June 1953, he was an instructor at the University of Colorado, Department of Psychiatry. In July 1953, he joined the staff of the Institute of the Jackson Memorial Hospital, Miami, Fla., where he serves as instruc-

tor in psychiatry at the University of Miami, School of Medicine. Dr. Tourney's special interests are medical history and the application of psychodynamics to cultural phenomena.

DEAN J. PLAZAK, M. D. Dr. Plazak was born in Wisconsin in 1927. He received his M. D. degree from the University of Wisconsin, School of Medicine, in 1951. He interned at Abington Memorial Hospital, Abington, Pa. At present, he is a resident and mental health fellow in psychiatry at the University of Colorado, Department of Medicine. Dr. Plazak's primary interests are psychiatry and medical history.

NEWS AND COMMENT

KATZ NAMED TUBERCULOSIS SERVICE DIRECTOR

Julius Katz, M. D., director of the bureau of tuberculosis control in state institutions in the Division of Tuberculosis Control, New York State Health Department since 1947, was named on July 2, 1954 as director of mental hygiene tuberculosis services. The appointment was announced jointly by the New York State Departments of Health and Mental Hygiene.

Dr. Katz now has his office in the Department of Mental Hygiene and is administratively responsible to the commissioner of mental hygiene, although he is responsible to the commissioner of health for advice and counsel in the field of tuberculosis control. In Dr. Katz' new position he is charged with the direction of the tuberculosis control program of the mental hygiene department institutions, including case finding, segregation, supervision, development of laboratory facilities, personnel training and general administration. In his former position Dr. Katz was also concerned with tuberculosis control in department of correction and department of social welfare institutions, and the notice of his appointment points out that he is still in a position to direct his former work. In the department of mental hygiene Dr. Katz now directs Health Department and Mental Hygiene Department personnel in the program of regular chest x-ray surveys and the interpretation of x-ray films.

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DR. BALSER IS SIXTH HUTCHINGS LECTURER

Benjamin Harris Balser, M. D., New York City neurologist and psychiatrist, and associate attending neuropsychiatrist at Montefiore Hospital, New York City, is the sixth lecturer in the series of annual lectures established in memory of the late Richard H. Hutchings, M. D. His topic is "Psychiatric Treatment of Adolescents."

The lecture is at 8:30 p. m., Monday, October 4, 1954 at the College of Medicine, Syracuse, N. Y. Neil D. Black, M. D., now consulting psychiatrist to the Veterans Administration Regional Office, Syracuse, gives the personal memorial to Dr. Hutchings. Both Dr. Balser and Dr. Black were formerly with the New York State Department of Mental Hygiene, to which Dr. Hutchings devoted his lifetime of medical service.

Dr. Balser, born in 1905 in Rochester, N. Y., received his bachelor's degree from the University of Rochester, a master's degree from Harvard and his M. D. from the University of Buffalo. He also holds the degree of Med. Sc.D. from Columbia. He was resident physician at the New York State Psychiatric Institute in 1933 and 1934; assistant resident and resident in neurology and neuropathology at Montefiore Hospital from 1934

to 1935 and later was clerk at Maudsley Hospital and National Hospital in London. He has been an assistant in neuropsychiatry at the Vanderbilt Clinic and is now a consultant psychiatrist to the Surgeon-General, United States Army.

The Hutchings memorial lectures, to be 10 in number, were established by a fund contributed by colleagues and associates of Dr. Hutchings to memorialize his work as an administrator, author, editor and teacher. Dr. Hutchings, who died in October 1947, had served as superintendent of both St. Lawrence and Utica (N. Y.) state hospitals. He was the author of the *Psychiatric Word Book*, a standard glossary for the psychiatric and allied professions, and of numerous scientific articles, and for many years was editor of THE PSYCHIATRIC QUARTERLY. He was actively interested for years in medical education and at the time of his death was professor emeritis of clinical psychiatry at Syracuse University.

DR. C. P. OBERNDORF, PSYCHOANALYST, DIES AT 72

Dr. Clarence P. Oberndorf, internationally known as a practitioner, teacher and writer of psychoanalysis, died in Mount Sinai Hospital, New York City, on May 30, 1954 at the age of 72 after a long illness. Dr. Oberndorf was one of the pioneers of psychoanalysis in America. He was one of the founders in 1911 of the New York Psychoanalytic Society. A graduate of Cornell in medicine in 1906 and of Bellevue Hospital in 1908, he served at the New York State Psychiatric Institute in the early days of that establishment at Manhattan State Hospital, Ward's Island, N. Y.

Dr. Oberndorf had become interested in psychiatry during his stay at Bellevue and he undertook postgraduate work in psychiatry in Europe before joining the Institute staff. He returned to Europe in 1922 to do further direct study of psychoanalysis with Freud. In addition to an active private practice, Dr. Oberndorf had been associated with Mount Sinai Hospital since 1913. He organized at Mount Sinai what is believed to be the first psychiatric outpatient clinic of a general hospital in the United States. Dr. Oberndorf taught neurology and was chief of the Neurological Clinic at the Cornell medical school from 1917 to 1923, and from 1915 to 1922 was adjunct neurologist to Bellevue Hospital. He was active in mental hygiene and philanthropic endeavors and was a director of Hillside Hospital for many years. He also was director of psychiatry of the New York Jewish Child Care Association, and organized a psychiatric service for that organization at what is now the Pleasantville Cottage School.

A member of the editorial boards of the *International Journal of Psychoanalysis*, the *Psychoanalytic Review* and the *American Journal of Psychiatry*, Dr. Oberndorf was the author of more than 125 scientific papers. He published three books: *The Psychiatric Novels of Oliver Wendell Holmes*, *Which Way Out?* and *A History of Psychoanalysis in America*.

GROUP PSYCHOTHERAPISTS TO MEET IN JANUARY

The American Group Psychotherapy Association, Inc., has announced that its twelfth annual conference will be conducted at the Henry Hudson Hotel in New York City on January 14 and 15, 1955. There will be a series of workshops and one of panel discussions on various aspects of group psychotherapy, in addition to the usual presentation of scientific papers.

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JUDGE BIGGS RECEIVES "ISAAC RAY AWARD"

Chief Judge John Biggs, Jr., of the United States Court of Appeals (Third Circuit), Wilmington, Del., has received the American Psychiatric Association's $1,000 "Isaac Ray Award" for 1954 for his contributions to the field of legal problems connected with mental disorders. The award was announced at the annual meeting of the association in St. Louis in May. As recipient of the award, Judge Biggs will give six lectures on the legal aspects of psychiatry in November and December 1954 at the University of California medical and law schools. They will later be published in book form.

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"MENTAL HEALTH IN THE NETHERLANDS"

The National Federation for Mental Health of the Netherlands has announced the publication of a short booklet in English, "Mental Health in the Netherlands," which reviews mental hygiene and psychiatric endeavors in that country. The author is A. Querido, M. D., president of the federation and director of public health of the city of Amsterdam.

The federation has requested this QUARTERLY to announce that it will send copies to anybody interested. The subject matter of this illustrated 24-page report ranges from general mental hospital care to educational problems, the mental health of children and occupational therapy. The address of the federation is Prinsengracht 717, Amsterdam-C, The Netherlands.

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DR. PERRY M. LICHTENSTEIN DIES AT 67

Perry M. Lichtenstein, M. D., widely-known psychiatrist and authority on forensic medicine, died on June 14, 1954 following a heart attack. He had been testifying in a case at the Queens General Court House, Jamaica, N. Y., when he was stricken suddenly in a court house corridor. A former medical assistant to the district attorney of New York County, and formerly physician to the old City Prison, the Tombs, Dr. Lichtenstein studied law and obtained a law degree so that he could qualify as both a psychiatrist and a legal expert. He was the author of more than 300 articles on forensic psychiatry, criminology and related subjects. He was also author of the book, *A Doctor Studies Crime* and was co-author with Dr. S. M. Small of *A Handbook of Psychiatry*. He was 67 years old.

G. A. BLAKESLEE, M. D., NEUROLOGIST, DIES AT 74

G. A. Blakeslee, M. D., a physician for 53 years, who had served five New York City hospitals as neurologist or psychiatrist, died at his home in New York City on June 9, 1954 at the age of 74. Dr. Blakeslee had been professor of clinical neurology and psychiatry at the New York Postgraduate Medical School and Hospital, a position he held until his retirement in 1946.

DEPARTMENT ISSUES EDUCATIONAL BOOKLET

A new booklet, *The Ear of the Beholder*, expounding the philosophy behind the public educational program of the New York State Department of Mental Hygiene, was issued by the department on July 15, 1954. The booklet, written by Mrs. Margaret M. Farrar, director of mental hygiene publications and public relations for the department, aims to show, in the words of Commissioner Newton Bigelow, M. D.: "why this department uses comic books, puppet shows, and similar media to teach the principles of good mental health." The booklet is available for distribution to all agencies and organizations engaged in mental health education.

PSYCHOANALYTIC INSTITUTE OPENS IN PARIS

An institute of psychoanalysis and a psychoanalytic center for consultation and treatment have been opened in Paris with Dr. Sacha Nacht as director of both. The institute is the only training center in France accredited by the International Psycho-Analytical Association. It was opened formally on June 1, 1954 with ceremonies at which Minister of National Education André Marie presided.

THEODORE P. WOLFE, M. D., DIES

Theodore P. Wolfe, M. D., former New York City psychiatrist, died in Taos, N. M., on July 29, 1954 following a long illness. He was 51 years old. Dr. Wolfe was an associate and fellow worker of Dr. Wilhelm Reich and was the translator of a number of Dr. Reich's books and articles from German to English.

MMPI COURSE ANNOUNCED

The University of Minnesota has announced a continuation course in the use of the Minnesota Multiphasic Personality Inventory from October 14 to 16, 1954 at the Center for Continuation Study at the university. Intended primarily for clinical psychologists, the course is also open to psychiatrists and other interested physicians.

MULTIPLE SCLEROSIS SOCIETY FINDS 35 TWIN PAIRS

The National Multiple Sclerosis Society has announced that it has located approximately 35 pairs of identical twins in the United States and Canada, one or both of whom are afflicted with multiple sclerosis. Medical director, Harold R. Wainerdi, M. D., announced the result of a nationwide appeal designed to promote research into the genetic background of multiple sclerosis. The society is continuing its appeal, with volunteers asked to communicate with the National Multiple Sclerosis Society, 270 Park Avenue, New York 17, N. Y.

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The American Journal of Psychoanalysis was founded in 1941 and is published by the Association for the Advancement of Psychoanalysis. Its purpose is to communicate modern concepts of psychoanalytic theory and practice and related investigations in allied fields. Vol. I through Vol. IV (single volume) 1941-1944—$3.00; Vol. V through XIII—1945-1953—$1.50 each volume. Subscriptions and back volumes may be ordered from the Association for the Advancement of Psychoanalysis, 220 West 98th Street, New York 25, N. Y.

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